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THE

Journal

of the
OKLAHOMA STATE MEDICAL ASSOCIATION



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THE JOURNAL

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NUMBER 1

The "Reformed Gall Bladder"*

G. H. MILLER, M.D.

TULSA, OKLAHOMA

More than fifty years ago, Oddi removed the gall bladder in healthy dogs, in order to determine its functional importance. While it is true this had previously been done, yet it did lead to his discovery of the sphincter muscle at the distal end of the common duct which still continues to bear his name. Sections made through the hepatic, cystic and common bile ducts revealed the ducts to have dilated two or three times their normal caliber. The cystic duct had been transformed into a reservoir for bile and had all the appearances of a newly formed gall bladder. These experiments led Oddi to conclude that natural forces within an animal's body made a tremendous effort to impound the bile until such time as it was needed in the intestines. In these experiments carried out later on by Drs. Judd and Mann, identical changes were observed. Most of the dilatation had been completed within sixty days following the cholecystectomy. After long and continued dilatation, the sphincter fibers were completely overcome and the bile continued to flow uninterrupted into the liver. The process as we now understand it after cholecystectomy, is dilatation of all of the bile ducts, including the cystic duct and later complete relaxation of the sphincter, thus permitting the bile to flow continuously into the duodenum.

The term referred to as "re-formed gall bladder" appears in the American literature following the work done by Dr. H. L. Beye, Professor of Surgery of Iowa University. He felt that the term was appropriate and expressed a clinical condition brought about and sometimes occurring following the or-

dinary cholecystectomy. After Dr. Beye's death, Dr. Frank R. Peterson, of Iowa University, continued with this work and collected many cases exemplifying the assertions previously alleged by his former chief. Dr. Peterson also retained the word "re-formed gall bladder" because he felt that it described a definite clinical condition. Numerous sections made from this new formed receptacle for bile were identical with and had all the appearances of sections taken from ordinary diseased gall bladder; in fact, their conclusions are that it is impossible to tell by histological sections alone, the differences between tissues from a "re-formed gall bladder" and tissues from the usual diseased gall bladder.

Most American surgeons have observed a dilated pouch formed out of the cystic duct following cholecystectomy; however, except for the work of Dr. Peterson and Dr. Beye, not much has been written about it in American literature. The German literature contains complete description of the reformed gall bladder and reveals that it is produced by dilatation of the stump of the cystic duct and lined by the mucosa. Their conclusions are that the stump of the cystic duct enlarges in the general enlargement and dilatation of all the ducts, as had previously been observed by Oddi in his experimental work; that the sphincter muscle contracts at the end of the common duct producing the obstruction and the secretion from the liver, causing sufficient hydraulic pressure to cause enough dilatation of all the ducts, to accommodate a quantity of bile equal to that previously retained in the gall bladder.

A re-formed gall bladder may be small in

*Delivered before the Section on General Surgery, Annual State Meeting, April 26, 1944, Tulsa, Oklahoma.

size, or as large as the original gall bladder and is completely lined by a mucus membrane. In addition, it is composed of a muscular layer, a fibrous layer, and peritoneum, depending upon the region through which the sections have been obtained. From the clinical material studied, it appears that a re-formed gall bladder may occur with or without obstruction within the common duct. It may produce all the signs and symptoms observed in acute or chronic diseases of the gall bladder and associated ducts. Very often this new formed gall bladder may contain stones. It may contain one large stone, or many small stones. Such stones may pass into the common duct, or obstruct the neck of the cystic duct and in either, may be accompanied by colic pain, chills and fever. This new formed reservoir is usually deeply imbedded in a mass of scar tissue and lies along side of, or just behind the common duct. It may occur within a few months after cholecystectomy, or be discovered many years later. The average is about four years following the first operation. There are some cases in which no clear line of demarcation can be made between the onset of the symptoms produced by re-formed gall bladders and the symptoms observed by the patient previous to his cholecystectomy. The symptoms are often identical with those of the original trouble. Jaundice may or may not be present. Not always do stones in the common duct produce jaundice, depending upon how nearly complete obstruction of the common duct occurs. Some of these patients present chills, fever and colic, with all the signs of a severe biliary tract infection. Most of these patients have had symptoms referable to the gall bladder and the biliary system over several years duration. With the re-formed gall bladder, stones may occur in the hepatic ducts, also in the common duct and in the gall bladder. Other specimens have been obtained which have not in any way been associated with stones, either in the gall bladder, or in any of the ducts, so that it is not possible to conclude a re-formed gall bladder is the product of back pressure produced by stones alone. While it is true stones are very often found within a new formed gall bladder, yet several very large re-formed gall bladders are on exhibition, which when removed, contained no stones. The stones associated with a re-formed gall bladder, generally contain calcium and for this reason are easily visualized with the aid of the x-ray.

Following the usual cholecystectomy, the cystic duct is tied with a ligature. This duct may be long or short, depending upon the place the ligation is made and in any event, a permanent diverticula remains, which has a secreting mucus membrane as its inner lining. Should obstruction occur at the junction

of the cystic and common ducts, secreted mucoid material accumulating behind this obstruction may be sufficient to produce a cystic formation of the entire stump. While most re-formed gall bladders are rather small, being one to three inches long and one-half to an inch in diameter, the size of one of these re-formed gall bladders is in no way in accordance with the symptoms produced within the individual. A small re-formed gall bladder containing numerous stones and considerable infection, tightly adherent in a mass of scar tissue in the region of the hepatic and common ducts is sometimes capable of producing alarming symptoms and often they resemble so closely the usual symptoms of a diseased gall bladder, they may lead one to suspect the existence of a re-formed gall bladder in any patient who has previously had a cholecystectomy and in whom later appears all of the classical symptoms of a diseased gall bladder.

Since a large percentage of these stones found associated with this unusual condition contain calcium, it is often very easy to come to a successful diagnosis with the aid of an x-ray; however, failure to visualize the re-formed gall bladder with an x-ray, does not permit us to rule out its presence. It can be identified definitely only by re-operation and careful dissection of all the ducts. If the pouch is large enough to be identified by general appearance and palpation, it should not be extremely difficult; however, if this re-formed pouch is small and densely adherent to the back of the common duct and surrounded by thick adhesions, it can be very easily overlooked. Dr. Frank Peterson in his article of December 5, 1941, read before the meeting of the Western Surgical Association, advises opening the common duct and exploration upward into the sac with a probe. Palpation of the end of the probe reveals the presence of the pouch and its relationship to the other ducts and permits the operator to determine the full length of the sac. In this manner, he suggests, it can be more easily identified and dissected out. It should then be carefully crushed with a forcep and ligated close to its junction with the common duct.

The following cases will show its occurrence with and without obstruction of the common duct:

Mrs. A. C., age forty, was operated upon for diseased gall bladder. At the time her gall bladder was removed, there were no large stones present within the gall bladder, or in any of the ducts. Several years after her first operation, a return of symptoms referable to the gall bladder region required her to again be examined. The x-ray revealed one large calcified stone, the size of

an English walnut, placed in the region of the normal location for the original gall bladder. At second operation, a re-formed gall bladder containing one large stone was dissected out and removed.

Mrs. E. was operated upon for the classical symptoms of gall bladder disease. At the time of operation, a highly inflamed gall bladder containing no stones was removed. Several months following this operation, her symptoms re-occurred in mild form. This was observed periodically over a period of four and one-half years when severe jaundice occurred and examination revealed a large calcified stone in the common duct. At operation, a gall bladder two and one-half inches long, highly diseased and containing several stones was removed. A large stone was removed from the common duct.

CONCLUSION

The so-called re-formed gall bladder is produced by dilatation of the cystic duct. It occurs following cholecystectomy in about ten to twenty per cent of the cases, accord-

ing to the available literature. It should be suspected in all cases in whom symptoms recur months or years after cholecystectomy. It may occur associated with obstruction in the common duct by stones, or without obstruction of any kind. It is best prevented by as nearly complete removal of the cystic duct as is consistent with safety to the surrounding structures.

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Fever Treatment*

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TULSA, OKLAHOMA

The significance of fever in its relation to disease has been a subject of speculation for meditative minds probably for thousands of years but the deliberate induction of fever for its curative effect, at least so far as medical records indicate, is a development of the past 70 or 80 years. Liedescorf¹, in a book published in 1865 said that from personal observations he had "concluded that febrile disease decreases the degree of psychic disturbance and that this action continues long after the cessation of the fever." In 1876 Rosenblum² purposely infected psychotic patients with relapsing fever and noticed that malaria frequently produces remissions in mental diseases. His report appeared in a relatively obscure medical journal and possibly for that reason did not receive much attention at the time. Later, and especially from 1910 to 1916, the use of vaccines and other substances that caused fever reactions, was reported by a number of workers in both

Europe and America. M. Matthew³ in 1910 said that in his opinion, fever in general was produced by protein split-products and suggested the importance of proteolytic ferments in this connection. In the course of time, it came to be noticed that vaccines had beneficial effects on diseases for which they were not specifically developed and in fact non-bacterial protein split-products (proteoses), with the fever they generated when injected parenterally, had a salutary effect in building resistance to a variety of diseases, infectious and non-infectious. In 1916 Miller and Lusk⁴ used typhoid vaccine (previously recommended by Penna, Kraus and Mazza of Buenos Aires for the treatment of typhoid fever) with good results in cases of arthritis and observed that similar results were obtained by the use of proteoses. In the same year Smith used normal horse serum in the treatment of gonorrheal complications.

The development period of treatment by fever-producing agents culminated in 1917 with the publication by Wagner-Jauregg of

* Delivered before Section on Dermatology and Radiology at the Annual Meeting, April, 1944, in Tulsa.

his success in treating paretics with innoculation malaria. For many years he had been searching for a satisfactory method of producing fever in psychotic patients, having tried tuberculin, typhoid vaccine relapsing fever and other agents with encouraging results but without being able to induce sufficiently high temperature reactions to effect actual cure. It is interesting that he had worked as assistant in the clinic of Leidesdorf¹ during the years 1883 to 1889 and may have gotten the inspiration for his later work there. In any case, his announcement was received with skepticism by many, which, however, was natural. The extraordinary results reported were so contrary to all previous medical experience that those who had not seen malaria work found them difficult to believe. But doubters who later had experience with therapeutic malaria were quickly converted to its use and today the efficacy of fever treatment in general paresis and other forms of resistant syphilis is accepted with question.

METHODS OF PRODUCING FEVER

Many different means have been employed to induce therapeutic fever. These include: physical heat-producing devices such as hot baths and packs, blankets, diathermy, short radio waves and air-conditioning cabinets; inoculation with fever-producing disease organisms, i.e., malaria, of tertian quartan and estivo-autumnal types, and relapsing and rat-bite fevers; substances of chemical and biologic origin, such as sulfur, proteoses, tuberculin, milk, patented preparations of one kind and another and bacterial vaccines injected intramuscularly and intravenously. Most of these have been abandoned and at this time only air-conditioned cabinets, malaria and typhoid vaccine are in wide use.

THE AIR-CONDITIONED CABINET

This is the so-called "hypertherm," an air conditioned cabinet containing an air humidifier, one or more electric heating units and a fan to circulate the air. A slide in the side of the cabinet can be moved to allow taking the patient's blood pressure and for other purposes. The patient's head is kept outside the cabinet and an attendant is present throughout treatment to count the patient's pulse, record temperature and give whatever care is necessary.

MALARIA

At present, only tertian malaria is in general use. Inoculation of the patient is usually by transfer of blood from a patient already infected. The blood can be injected either intracutaneously, subcutaneously, intramuscularly or intravenously but the intravenous route is most commonly used because the paroxysms start in shorter time after it and 5 cc can be injected intravenously without

fear of serious reaction. Care must be taken that the blood of the donor does not contain estivo-autumnal parasites. Unlike mosquito-born malaria the infection given by inoculation is easily controlled by quinine.

TYPHOID VACCINE

Ordinarily, the regular combined typhoid-paratyphoid vaccine containing 1000 million typhoid and 500 million each of paratyphoid A and B bacilli per cc is used. It can be given either intramuscularly or intravenously, depending on the nature and degree of reaction wanted. When temperatures of 105 degrees F. and over are desired, the concentrated vaccine mentioned above must be given intravenously according to a method previously described. A diluted form of the vaccine, which can be used to produce lower temperatures, is not satisfactory for this purpose. Vaccines of different manufacturers vary in their ability to produce fever and one of these is considered by the producer to be too dangerous to use intravenously.

COMPARISON OF METHODS

In a consideration of these methods of fever therapy one feature stands out to separate them. The air-conditioned cabinet on the one hand is a mechanical device that elevates body temperature by physical means; malaria and typhoid vaccine, on the other, induce fever through immunologic responses.

AIR-CONDITIONED CABINET

So far as their practical use is concerned, there are advantages to each. The air-conditioned cabinet allows regulation of the body temperature, it permits treatment to be adjusted to the patient's physical condition and convenience, there probably is less discomfort and little or no debilitation associated with its use. On the other hand it is necessarily quite expensive, requiring costly apparatus and the constant presence of a trained attendant; it is available only in the larger centers and is not well suited to cases in which there is mania or delirium nor to treating numbers of patients at the same time.

MALARIA

Malaria is the most widely used and best known of the three. It produces high fevers, is inexpensive, is well suited to treating manic or delirious patients and can be used on large numbers with a minimum of work and difficulty. It has a number of disadvantages, however; it is not always readily available, it does not permit regulation of the temperature, must be employed in a single course without interruption, and cannot be modified to conform to the patient's physical condition or convenience. It is associated with a maximum of discomfort and debilitation, and is not uniformly fever producing—some per-

sons being partially or wholly insusceptible, either aborting the infection before the course is complete or not acquiring the disease at all. Finally and in addition, it gives the patient a second disease.

TYPHOID VACCINE

Typhoid vaccine has most of the advantages of both the foregoing agencies and only a few and minor disadvantages. It is simple, inexpensive, and available everywhere. It does not require costly apparatus or trained attendants, it permits regulation of the temperature and can be suited to the patient's physical condition and convenience. It is well adapted to cases in which there is delirium or mania and to treating numbers of patients at the same time; it does not give the patient a second disease. Its only disadvantage is that it causes some discomfort to the patient, something that at present cannot be avoided in fever treatment of any kind.

CHOICE OF METHOD

The choice of method to be used depends on the individual considerations of the case and on the disease to be treated. Malaria is suitable mainly for the treatment of cases requiring high fever, in which the outlook is grave and in which somewhat desperate measures appear to be justified. These include paresis and other resistant types of syphilitic infection and such diseases as granuloma fungoides. It is especially adapted for use in mental hospitals where comparatively large numbers of patients must be treated with a minimum of professional help. Fever cabinets and typhoid vaccine can be used in all types of cases.

As to therapeutic value, the comparative worth of these methods has not yet been determined. Malaria has been known longest and is most widely used. In this country the hot air cabinet, with its dramatic appeal to the American mind, is at present popular.

The possibilities of typhoid vaccine in the production of therapeutic fever have not been fully exploited and are not generally known. For example, G. B. Tayloe⁷ in a recent article says that foreign proteins (typhoid vaccine, etc.) "will not produce and maintain the necessary elevation of temperature desired," yet from my own experience I know that if properly used, typhoid vaccine will produce temperature as high as it is safe to have them go—107.5 or 108 degrees F. and has induced fever of 107 F. and above for 14 consecutive days, with complete clinical cure in cases of general paresis which had previously been treated unsuccessfully by both malaria and hot air cabinets! Not only that, but without treatment of any other kind afterwards. However, in the use of any of these methods, experience is necessary to obtain the best results. As with everything

else, one is not likely to do everything right the first time—perseverance and sensitive attention to detail are necessary. In my experience typhoid vaccine is more readily adaptable than malaria and is fully equal to it in therapeutic effect.

MECHANISM OF THERAPEUTIC ACTION

Fever treatment is purely empirical—nothing is definitely known about how and why it works. All we know for certain is that it does work and the puzzling thing about it is that it can be so effective in such a variety of unrelated and dissimilar conditions. For a good many years it has been thought that fever increases specific antibody titer but recent work seems to show that, under certain experimental conditions at least, hyperpyrexia actually lowers specific antibody titer.⁸ Experimental work done on this subject is conflicting and for the most part, unconvincing. The fact is that fever reactions, however produced, are accompanied by complex physiologic and immunologic processes that are hard to evaluate and still harder to determine the significance of. One gains the impression from reading of this work that the experimental conditions and those surrounding the treatment of human beings are not entirely parallel and that the work therefore is not conclusive. It is one thing to raise a rabbit's temperature by placing him head and all, into a hot humid box and another to cause fever in a human being by inoculation with malaria or typhoid vaccine or even for that matter, through the medium of an air-conditioned cabinet. We are justified in doubting whether, in view of the difference in structure and physiology of the two animals, conclusions drawn from experiments on the one are necessarily valid for the other.

At any rate, in the attempt to explain the mechanism by which fever therapy operates, a number of factors must be considered. The effect of fever temperatures on the infecting agent, when present, the permeability of the capillaries, the rate at which immune bodies and agencies of one kind and another, such as antibodies, ferments, coagulins, complement, and the various defensive cellular elements are produced and destroyed at certain temperatures, the rate at which chemical reactions per se occur, the variations in the blood supply, the effect on the function of the central and autonomic nervous systems and other organs in the body, all must be weighed. It is no wonder that we know so little about the subject, that the interpretations and results of experiments are so confusing and that so many false conclusions are drawn. For example, Boak, et al⁹, found that the thermal death point of spirochetes in vitro was five hours at 39 degrees C., three

hours at 40 degrees C., two hours at 41 degrees C., and one hour at 41.5 degrees C. Bessemans³⁹, using hot baths on chancres in rabbits and man, concluded that two hours at 40 degrees C., or one hour at 42 degrees C., was lethal to spirochetes in vivo, while Levaditi¹¹ found that in a large percentage of rabbits, syphilis could be cured by temperatures lower than the supposed thermal death of the spirochete. Noguchi on the contrary, said that spirochetes would survive many hours at even 45 degrees C., (113 degrees F.) if kept under strictly anerobic conditions and properly balanced nutrient substances!

It is obvious that we cannot be sure of ground and that we must beware of coming to hasty conclusions, especially when they may have far reaching effects on the lives and future of our patients. To illustrate, I should like to call attention here to the patient fallacy so commonly accepted as truth, that a certain degree of fever maintained for a certain length of time constitutes adequate treatment, and is equivalent no matter how it is produced or in how many sittings it is taken. For my part I am unwilling to admit that 50 hours of fever at 105 degrees or over, taken in 10 sittings is equivalent to 15 paroxysms of fever reaching maximum heights of 107 degrees and more produced by malaria or typhoid vaccine, even though the time the temperature remains over 105 degrees may total only 20 or 25 hours. I prefer to believe with Moore¹², O'Leary¹³ and most fever therapists that the beneficial effect of fever (especially in neurosyphilis) depends on some factor or factors other than the rise in temperature.

INDICATIONS FOR TREATMENT

Fever therapy has been used in many different diseases but has not been uniformly effective in all and in present practice is employed in a dozen or so. Among these are resistant syphilis, especially of the nervous system, ophthalmologic conditions, such as perititis, uveitis, corneal ulcers and panophthalmitis, in arthritis and rheumatic states, in resistant gonorrheal infections of various kinds, in undulant fever, bronchial asthma, multiple sclerosis, chorea and certain dermatoses. Its use is best known in general paresis and resistant syphilis but fever therapy can be quite effective in other conditions as well. I believe if the advantages of properly given fever therapy in these conditions were generally recognized it would be put to much more frequent use, to the benefit of many unfortunate patients.

CONTRAINDICATIONS

Contraindications to fever therapy are usually listed as advanced arterial, cardiac and renal disease, pulmonary tuberculosis, hemorrhagic conditions, such as hemophilia and

bleeding ulcers, extreme exhaustion state and diabetic acidosis. It might be mentioned also that instances are on record of reactivation of quiescent infections from previous illnesses, such as appendicitis, cholecystitis, thrombosis, etc. For my own experience I believe that we are sometimes frightened too easily and that in many instances in which these contraindications are present fever therapy, properly given, can be effectively used.

CONCLUSION

Fever therapy is destined eventually to come into wider use but as yet too few of us recognize its great value. For the most part, we are inclined to regard it as a last resort, to be tried in desperate cases after all other types of treatment have failed. While in my opinion, in the group of diseases previously listed, there is seldom a case so advanced that fever treatment may not be of benefit if given a proper trial, yet (and this is an important point) the greatest opportunity to obtain results occurs relatively early in the courses of the disease, before organic damage has progressed to the hopeless destruction of functioning tissues. Fever treatment is by no means a mere adjunct and last resort—it is a therapeutic procedure of the highest value in its own right and should be employed with the conscious knowledge that in it we have an effective means of accomplishing results impossible through any other agency.

DISCUSSION

C. P. BONDURANT, M.D.,
OKLAHOMA CITY, OKLA.

Dr. Nelson was kind enough to send me a copy of his paper in advance of the meeting and I appreciate very much the opportunity of discussing it. He recorded the basic principles and has added some new findings to the history of fever therapy. His unbiased discussion of the methods of producing artificial fever is clear and concise. My experience in this field is limited mainly to two of these methods, namely, malaria and typhoid vaccine, and I have observed many cases treated by the air conditioned cabinet or hypertherm. I have been disappointed in the total results and the danger in this latter method.

Malaria has been the method of my choice in many institutions where great numbers of patients are cared for and where a particular strain could be maintained. I was interested to find in Wagner-Jauregg's Clinic in 1927 that he had transmitted his malarial strain 2,600 times. I find the use of typhoid vaccine very satisfactory and productive of results comparable to any other method. I think the principle of a method of fever

which has as its basis the production of the fever by the patient himself is much more effective than one where the temperature originates from outside the body. The experience of producing repeatedly a fever within his own system calls forth and exercises many protective mechanisms neglected where the heat originates from an exogenous source.

Dr. Nelson offered us, in 1932, the secret of producing fever by typhoid vaccine, namely, the introduction into this form of therapy of the repeated or booster dose. With this method it is possible to produce almost any fever desired. Each patient, however, presents individual problems and the technique of the administration of typhoid vaccine cannot be haphazardly undertaken. Fever can be produced and maintained at a desired level where the patient is physically fit for this experience. Recently it has been my practice to employ a modification of Dr. Nelson's original method, that is, the use of a light cradle heated by two bulbs and the administration of arsenicals coincident with the fever through a considerable part of the

course of the fever therapy according, to the condition of the patient. I also employ supportive treatment in the form of glucose, vitamins, etc.

It has been a pleasure to study and discuss Dr. Nelson's paper.

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The Present Status of Pain Relief During Labor*

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At intervals during the years, it is appropriate to review certain procedures in the various medical specialties, and particularly is it fitting at this time to devote a short discussion to relief of pain during labor.

Fortunately or unfortunately, the interest of the public along medical lines centers itself as often upon the problem of birth and its attendant management as upon any other medical condition. Whenever a new drug or new method of administration is discovered, due to its news value, its attributes are discussed freely in the public press and in various periodicals, and frequently the lay public has much more conversant knowledge of it, or at least thinks it has, than many practicing physicians. This was particularly true, I am told, of twilight sleep which Gauss in Germany introduced in 1907. To my personal knowledge, various articles appeared in the lay press also in 1924 when Gwathmey

introduced synergistic analgesia, in 1929 when the barbiturates became popular, and later when paralydehyde was presented. At the present time with the numerous articles concerning continuous caudal anesthesia, the public has again taken up the cry and apparently accepts this latest development as they have each of the others in turn, as the panacea for a painless, safe and almost enjoyable procedure.

Because of the tendency of the public to make strong pressure upon the physician to alleviate pain in the so-called fashionable method, it is extremely important that we as physicians view this entire picture in perspective so that we may be the proper judges as to the most efficient method to relieve pain during labor.

It is most important to decide first what the criteria are for a satisfactory method for conducting labor. Obviously the most important single factor is safety to mother and baby, both in relation to the maternal and

* Read before Section on Obstetrics and Gynecology at Annual Meeting April 26, 1944 at Tulsa.

fetal mortality and also in relation to the actual margin of safety which various drugs possess. For instance, the method of twilight sleep as described originally with morphine and enough scopolamine to keep the patient in continuous amnesia may not have actually increased fetal mortality in the hands of its proponents who very carefully conducted the labor. However, even the proponents of this method admitted that there were many more apneic infants where these drugs were used in large amounts, and when this method was taken up by the great mass of physicians, a number of these apneic cyanotic infants did not survive. Another important factor to be considered is the convenience of administration. I have heard McCormick of Indianapolis extol the virtues of his ether-oil preparation. In his hands where the entire hospital personnel is trained to carry out the details of administration minutely, this method is most satisfactory. I have used it myself on many occasions and realize its advantages. It is comparatively safe for mother and child and it usually accomplishes its purpose as far as pain relief is concerned. It is untidy to administer, it is often not retained unless attention is paid to the most minute detail in its administration, and frequently it is condemned because the patients become difficult to control. The administration of paraldehyde carries with it to some extent the disadvantages of ether and oil. The administration of the barbiturates in combination with other drugs, especially scopolamine, is easy but in a certain percentage of cases, again the patient becomes quite excited and difficult to control. If the physician is well acquainted with this condition, he frequently is able to resort to drugs to aid in controlling the nervousness and hysteria.

All these methods for relief of pain, besides the annoying complications of administration or excitability, carry a certain small percentage of danger to the baby if they are administered at the improper time, in too large dosages, or if the patient is not in the proper environment for control, that is, we all know that depressant drugs act more efficiently when the patient is in a darkened room, if her ears are plugged, if her family is not in attendance and if she is cared for by a competent attendant who is thoroughly versed in taking care of a patient during labor.

Caudal anesthesia is not new in obstetrics, but the idea of continuous caudal anesthesia is. It is the most spectacular of all the methods of relief of pain in labor that I know, when it is successful. Hingson and Edwards and various other writers have described its use in various articles. The technique men-

tioned by Hingson and Edwards is as follows:

"1. The patient is placed in the modified left lateral Sims position. The sacral and coccygeal area is cleansed with ether and prepared with one of the antiseptic tinctures.

"2. The tip of the coccyx is palpated with the middle finger of the left hand, and the thumb is used to find the U or V shaped notch indicating the sacral hiatus between the sacral cornua. This is usually about $1\frac{1}{2}$ or 2 inches from the tip of the coccyx. In cases in which there was a failure of the inferior sacral arches to fuse into the bony roof of the sacrum, this hiatus may be $2\frac{1}{2}$ to 4 inches from the inferior caudal tip. Experience with the standard single caudal injections is a desired prerequisite for the success in the use of the continuous method.

"3. The middle finger of the left hand then changes place with the thumb and marks the spot for raising the initial skin wheal.

"4. A special apparatus has been developed for this procedure. The analgesic agent recommended is 1.5 per cent metycaine in isotonic solution of sodium chloride. Two Gm. of the drug diluted in approximately 125 cc. of saline solution in the reservoir bottle will most nearly approach this concentration. With a few cubic centimeters of this solution, skin anesthesia is obtained by raising a skin wheal with a 25-gauge needle and deeper infiltration to the sacrococcygeal ligament with a 2-inch 22-gauge needle.

"5. The special malleable stainless steel 19-gauge needle is then inserted in the midline in the direction of the hiatus at about a 45 degree angle with the skin.

"6. As soon as the bevel of the needle pierces the sacrococcygeal ligament, its reinforced metal collar is depressed through an arc of 1 to 3 cm. and the needle is thrust slowly and evenly in the midline for 1 to 2 inches within the sacral canal, where its bevel should lie inferior to the lowest extent of the dural sac. This may be ascertained by measuring on the skin with the stilet the approximate extent of the needle. The point of the needle should always be below the level of the second sacral spine.

"7. The small section of tubing with special adapter is then slipped over the collar of the needle. The Luer-Lok syringe is securely attached to the adapter. A careful aspiration is performed.

"(a) Should clear spinal fluid be obtained the needle has pierced the dura and lies within the subarachnoid space. In such event the needle should be immediately withdrawn and the case ruled unsuited for caudal analgesia for fear of producing a massive spinal in-

jection of the analgesic drug. Anatomic anomalies with such low lying dura are rare. A failure to recognize this situation would be extremely hazardous, if not fatal.

"(b) The withdrawal of pure blood indicates that the needle has pierced a small blood vessel in the highly vascular peridural space. In this event the point of the needle should be moved until blood can no longer be obtained. Then the injection is continued cautiously.

"8. The danger of intraspinal injection, with appearance of spinal fluid previously mentioned can be minimized if a trial dose of 8 cc. of the solution is injected and further action delayed for ten minutes to see that a low spinal anesthesia does not ensue. Without relief of pain or loss of motor power in the lower extremities in ten minutes after injection, one can safely assume that the subarachnoid space was not entered.

"9. After these precautions have been carried out, the hose end of the special 4-foot rubber tubing is secured over the collar of the special caudal needle. The tubing should previously have been connected to the remainder of the apparatus, all air having been expelled by filling the entire system with metycaine solution.

"10. With the palm of the left hand firmly pressed over the skin area against the dorsum of the sacrum, 30 cc. of 1.5 per cent solution is slowly injected.

"11. Five per cent sulfathiozole ointment is then generously spread around the collar of the needle.

"Indications that the solution is being injected into the peridural space of the sacral canal: (a) The patients usually experience a sense of fullness progressing to an uncomfortable sensation in one or both legs as the solution circumscribes the perineural components of the sciatic nerves. This sensation can be minimized by slower injections.

"(b) There will be a progressive analgesia in the areas supplied by the coccygeal, hemorrhoidal, perineal, pudendal, ilioinguinal and iliohypogastric nerve. Analgesia should be complete in twenty minutes.

"(c) There is relief of abdominal uterine cramps within five to fifteen minutes after injection.

"(d) Pronounced vasodilatation, cessation of sweating and increase in temperature of the skin of the feet will ensue within five to fifteen minutes after injection. This phenomenon is often noticed on one side several minutes before it occurs on the other.

"Indications that the Solution is being injected outside the sacral canal: (a) Failure of the injection to relieve pain within thirty minutes. (b) The appearance of an 'injec-

tion tumor' superficial to the dorsum of the sacrum.

"Supplementary Injections.—12. The supplementary injection will depend on the rate of metabolism of the drug by the individual patient. In our experience 20 cc. of additional solution injected every thirty to forty minutes is sufficient to keep the parturient comfortable for the entire course of labor. We have continued our supplementary injections for a maximum of thirty hours and for an average of seven hours.

"We consider this method of analgesia to be a specialized procedure which requires special training in order to attain uniform satisfactory results."

The obvious advantage of continuous caudal anesthesia when successful is a truly painless labor. The first stage and early second stage are said to be of somewhat shorter duration. The baby suffers no depressant or other ill effects and this method would be particularly applicable for premature labors. The disadvantages in regard to universal use of this method are that there is a high incidence of forceps deliveries due to the absence of the expulsive powers of the mother, this method is not applicable for home deliveries, and during the course of labor there must be constant attendance upon the patient. There are certain contraindications to this method such as deformities of the sacrum and injection into the spinal canal. In order to carry out the method successfully a thorough knowledge of the anatomy of the sacral region is necessary and there must be considerable practice to carry out the technique of insertion of the needle. It has impressed me quite forcefully that the technique always seems much simpler to trained anesthetists than it is to the general run of doctors.

From the entire foregoing discussion I do not want to create the impression that I am not in favor of various forms of pain relief. I merely, thus far, am attempting to point out that we still do not possess the panacea for relief of pain. My opinion, and what I have attempted to teach my students concerning the management of the patient in labor in regard to pain relief, is this: during the prenatal period, observe the patient constantly and carefully. Evaluate her fears and temperament. Win her confidence. Tell her frankly, if she inquires, that you will do all possible that you can to alleviate her discomfort as long as it is not dangerous to her or the baby. If that is achieved, well and good. I believe that there is much more advantage in this so-called psychotherapy and your ability to have the patient realize it, than a great many people admit. Explain carefully the symptoms of the onset of labor

and assure the patient that she will receive careful attention. There is no doubt that patients so conditioned during their prenatal period have more normal and satisfactory labors than those whose physicians act as though there is some mysterious barrier between them and the patient and who refuse to discuss the anticipated events with her. Explain further to the patient that if she suffered no pain there would be no labor, but that when the pains are of sufficient severity, relief will be given.

The attending physician may prefer any of the aforementioned methods of analgesia. He should be thoroughly conversant with their shortcomings and their dangers, which of course he should not divulge to the patient. He must know in detail the method which he uses, whether it be ether and oil, barbiturates, paraldehyde, caudal or any other method. A great deal of the dissatisfaction of these methods is because not enough attention is paid to detail. It is also important to recognize contraindications when present, such as proctitis for ether and oil per rectum, abnormalities of the sacrum for caudal anesthesia, etc. A most important consideration to keep in mind is that premature babies do not tolerate depressant drugs, and that except for local and caudal anesthesia, a minimal amount of drugs should be used for premature labor. Except in the well regulated clinics, details of darkening the room, of forbidding visitors, of careful auscultation of the fetal heart and of strict asepsis, are not adhered to nearly as well as they should be. It is recognized that during the war with the shortage of trained attendants, with the private physicians being overworked, and with the tempo of life in general being increased, that all of us are prone to omit a great many details. If this is done, however, we cannot expect the excellent results which various men report of various methods.

No discussion of obstetrical analgesia and anesthesia is complete without emphasizing also that every obstetrical attendant should be well versed in the resuscitation of new-born babies. This may be considered as supplementary in this paper, but simple methods of warmth and keeping the air passages open are fundamental, and entirely too many physicians neglect these simple safeguards. The administration of oxygen is a most worthwhile procedure, but too many times a mask will be placed over the face of an apneic baby and the oxygen turned on, but since the baby is not breathing it does not receive the effects of the gas. It is well for the physician to be versed in the method of insertion of a tracheal catheter. This serves a double purpose: mucus can be sucked out of the throat or trachea, and after this, oxygen may be gently fed to the baby's lungs.

We are still hoping to find a type of analgesia which will be the last word for the women in labor. Each particular group has its favorite method, and the greater the knowledge of the advantages and disadvantages of that method and the greater the observation to details of administration, the more successful will it be.

Caudal anesthesia, I believe, in certain limited environments and among the better technicians will prove of much benefit. Because of the necessary careful observation and difficulties in technique, it certainly is contraindicated in the home, and its cause of increase of operative deliveries, leaves just as much to be desired as other methods. My experience with this method is limited to very few cases because I entered the Army before much attention had been paid to it. Of the other methods, I speak from experience. My own general routine has been to use sodium amytal and scopolamine and occasionally I use morphine either as a substitute for sodium amytal or as a supplement.

I have not discussed the inhalation anesthetics which are used for delivery. Because of the high oxygen content used with cyclopropane, I consider it most desirable, but the disadvantage of needing a trained anesthetist and expensive apparatus must be admitted. Ether is probably the most satisfactory anesthetic for universal use. Chloroform to a surgical degree carries too small a margin of safety, nitrous oxide and theylene have the same disadvantages as cyclopropane and are not as effective in my opinion.

To supplement these methods also, local anesthesia is very popular with those who have used it to a great extent and in certain cases where a general anesthetic is contraindicated, it may be given to supplement the various forms of drugs given hypodermically, by mouth or by rectum during the first stage of labor.

DISCUSSION

HENRY B. STEWART
TULSA

This presentation by Major Starr is a most complete story of agents and methods available for pain relief during the stages of labor. The bulk of his thesis is concerned with the most modern method of pain relief, continuous caudal anesthesia. Articles on this technique have appeared now for two years in most of the current journals. The value of continued papers on the subject is to be found in the author's appraisal of the method and the addition of suggestions for improvement in making the procedure as successful as possible.

I want to add my endorsement of his open-

ing statement relative to the appearance of new scientific information in lay magazines before the profession has had the opportunity to evaluate the data and its problems. Usually such articles portray a new drug or technique as a cure-all, meant to replace all old standard and time tested procedures and pictured as fool-proof and adaptable to every type of patient. It is unfortunate that continuous caudal anesthesia was introduced in this way and during the war period when medical manpower was taxed to the limit. It becomes the duty of every physician to take the bull by the horns, so to speak, and educate himself in the problem. He should never allow his patient to literally force him to employ a drug or special technique until he knows all the answers.

Dr. Starr mentioned that experience in single caudal injections was a desired prerequisite before using this technique. I might add that the success or failure of the method at the start will rest entirely with previous experience and adeptness in caudal puncture. Practice is the only solution to perfecting the technique and reducing the percentage of failures. Those who have been using this technique for a considerable period of time prefer a needle which is not longer than 3 inches. If it is found on subsequent injections that the needle has been pushed into the sacral canal further than when the initial injection was made, there is no way to absolutely determine whether you may now be within the dural sac but to go thru the precautionary measure of injecting 6 or 8 cc. and waiting to ascertain whether spinal anesthesia has ensued. With one or more supplementary injections it is usually found that the solution gradually ascends along the dura to bathe higher spinal segmental nerves and the patient therefore loses motor power in the legs. Hence it would be extremely easy to inject 20 or 30 cc. intradurally on any subsequent supplemental injection and not be aware of it at the time.

Should such a thing happen and dangerously high spinal anesthesia develop with respiratory paralysis an immediate spinal puncture should be done to drain off the solution and resuscitative measures instituted. Prompt action usually will prevent a fatal accident. Some obstetricians do not have a higher incidence of forceps deliveries with caudal than without it. A cooperative patient can exert considerable expulsive power with her abdominal muscles and aid delivery. A hand on the fundus with the extreme relaxation of caudal will deliver most babies without forceps except in disproportion, which is supposed to be a contraindication for the employment of the method.

The closest attention to all the details from prenatal care through the second stages of

labor as pointed out in the paper is worthy of a second mention here. Whether you use caudal, rectal, paraldehyde, barbiturates or what have you, the success of your method is directly an adherence to all details involved. The simple act of performing caudal puncture successfully does not answer the question of good management of the relief of pain. I think obstetricians should give their patients barbiturates in moderate dosage while labor is progressing under continuous caudal anesthesia and thus gain the protection afforded by barbiturates against overdoses or side reactions of metycaine. Barbiturates in small or moderate dosage in the latter part of labor are not objectionable or depressant to the baby.

There is no question but what continuous caudal anesthesia is a sizeable contribution in the relief of labor pain and that it is here to stay in a big way. It behooves every obstetrician to learn how to give satisfactory caudal anesthesia or have an anesthetist who can do it for him. The latter arrangement is much to be desired where professional anesthetists are available. As the author pointed out, caudal should not be used in the home. Precipitate deliveries are quite uncommon in organized obstetrical departments despite the fear most nurses and some physicians have of its frequent incidence.

I wish Dr. Starr had discussed some of the merits of good inhalation anesthesia during the second and third stages of labor. It would appear that these are relegated to the last consideration either because of their impracticability or their lack of effectiveness.

When one reviews the present status of pain relief during labor and enumerates the agents and technique at our disposal I think, from the standpoint of past results, he must place the gases such as nitrous oxide, ethylene and cyclopropane first on the list. Unless we wish to confine our evaluation to home deliveries, very small hospitals and maternity homes, where drop ether and chloroform alone are available, the use of these gases during the second and third stages is well understood by patient, obstetrician and anesthetist. They are quite satisfactory in regard to safety for mother and baby; they produce analgesia or anesthesia of any duration or depth; they are controllable at any moment of their administration and are usually devoid of serious sequelae and complications. Until the majority of men, both anesthetists and obstetricians, have the time and opportunity to perfect their techniques in caudal anesthesia—gas anesthesia with or without the barbiturates will be more widely used and more satisfactory than other techniques. I predict in time continuous caudal analgesia will replace most other kinds of pain relief during labor.

Byron's Lameness

Dr. Livingstone the elder was accoucheur to the Duchess of Gordon in 1768, when she had a son at Gordon Castle; and he also attended, while she lived in Aberdeen, Lord Byron's mother, Mrs. Gordon of Gight, in Long Acre. He had some plan for curing her son, the little Lord Byron, of his unfortunate lameness, by ordering his leg to be tightly bandaged every night when he went to bed. The bandaging was given in charge by the sprightly mamma to Byron's nurse, May Gray, an Aberdeen girl. The little lord's sleep being disturbed, he induced the girl to teach him the Psalms of David and tell him Scripture stories every night after he was in bed. These afterwards found voice in the celebrated "Hebrew Melodies." Dr. Livingstone was unable to restore the deformed limb, but corresponded at some length and gave the lame boy all the benefit of his skill and experience. From those who saw Lord Byron's body after death, it was evident that his deformity was incurable; but Dr. Livingstone, by bandaging, so assisted it that the poet as a young child wandered freely alone all over Aberdeen.—*Aberdeen Doctors, At Home and Abroad. Ella Hill Burton Rodger, pp. 30-31. William Blackwood & Sons. Edinburgh and London. 1913.*

Sir Charles Bell and His Famous Work on the Hand

Sir Charles Bell, whose patronage was also courted by the Medical Society, brother of John Bell of Edinburgh, was Professor of Anatomy and Surgery to the College of Surgeons, and in his later years Professor of Surgery in Edinburgh. His water-colour drawings of anatomical subjects were very fine; and amongst other works, he wrote on 'The Hand,' the Bridgewater Treatise on 'The Power, Wisdom, and Goodness of God as manifested in the Works of Creation,' receiving the prize offered of a thousand pounds. He was one of the most hard-working men of his day, and was looked on as the worthy successor of John Hunter. His life tells of failures and successes, of a devotion to science poorly paid, whilst a medical practice would have given a for-

tune.—*Aberdeen Doctors, At Home and Abroad, pp. 117-118. Ella Hill Burton Rodger. William Blackwood and Sons. Edinburgh and London. 1913.*

The Fear of Death

Growing out of his parochial visits, Ralph Waldo Emerson said, "When I talk with the sick they sometimes think I treat death with unbecoming indifference and do not make the case my own, or, if I do, err in my judgment. I do not fear death. I believe those who fear it have borrowed the terrors through which they see it from vulgar opinion, and not from their own minds. . . What are your sources of satisfaction? If they are meats and drinks, dress, gossip, revenge, hope of wealth, they must perish with the body. If they are contemplation, kind affections, admiration of what is admirable, self-command, self-improvement, then they survive death and will make you as happy then as now."—Perry Bliss. The Heart of Emerson's Journals, page 53. Boston and New York.

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• THE PRESIDENT'S PAGE •

It is again time to make plans for the Annual Meeting. The dates have been fixed for April 23-25 and, as you know, the meeting will be held in Oklahoma City. Accommodations have been provided in the Skirvin Hotel for all sections and all general assemblies. We shall give each section as much time and space on the program as it is possible to do under the circumstances. At any rate, the "stream-lined" program of the past two meetings will be abolished.

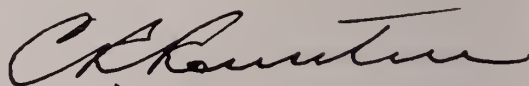
Your Association has always advocated a strong, well-balanced, scientific program around which the meeting should be built. This year, travel conditions permitting, we expect to have a number of outstanding guest speakers representing the various specialties to address the general meetings and to participate in the section meetings.

The Scientific Work Committee will shortly make an appeal through the Section Officers for papers from the membership. How many of you will respond? How many of you will take the necessary time to prepare a paper worth presenting and publishing? The writer was a member of the Scientific Work Committee for three years, and the lack of interest the rank and file of the doctors have in this matter is appalling. As a result of your failure to respond we have had a relatively small group of men who have appeared on the program too often. This is not so much to their credit as it is to the discredit of those of you who have failed in your responsibility to your Association.

The poor response to appeals of this kind is deplorable. If there ever was a time in the history of medicine in the State of Oklahoma when real progress and advancement can be made, that time is NOW. We can show the people of this State by our words and deeds that we really mean business. Society is turning to organized medicine for leadership and we must not fail. Let each member resolve to do his or her individual part so that the sum total of our efforts will be a force which cannot be denied. Therefore, I urge you to realize your responsibility and to contribute to the scientific program whenever you are called upon.

We need your help! We must have more members who will take part in the Scientific Program!

Very Sincerely,



President.



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*Tice, F.; "Practice of Medicine".

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EDITORIALS

COUNCIL MEETING

In behalf of good medicine in the State of Oklahoma, which in a broad sense means in behalf of the citizenry of the State, your Council met in the State Association office in Oklahoma City on January 7, 1945.

Again the author of this editorial is pleased to say the meeting was impressive because of the unselfish devotion of the officers and the members of your Council to the cause of the medical profession and through the profession to the people of the State.

At this time certain committees are handling problems of great importance. Some of these problems are in the hands of the Committee on Legislation. For your information it can be said that all these problems have been carefully surveyed by the Council and that all have had free discussion in an effort to secure a level vision on the principles involved and to decide upon the best course of action. The various political angles were discussed with a view of ways and means to cope with the same. The latter came under the scrutiny of the Council not because the medical profession is contemplating a political career but an alertness with adequate council for the purpose of forwarding legit-

imate medical and public health legislation and to protect the people and the profession from ill-advised legislation.

The members of the State Association will be interested in the fact that Dr. Tom Lowry, Dean of the Medical School, talked to the Council about plans for increased appropriations to support a badly needed building program for the purpose of improving scientific facilities and increased capacity for students in the medical school and for patients in the hospitals. Every doctor in the State should actively support this program.

It was agreed that the time is ripe for post war planning. It was pointed out that the general trend is fraught with a multiplicity of ideas and plans which may lead us into many serious errors unless the medical profession seizes the opportunity and offers stabilizing and forward-looking direction of the program insofar as it concerns medicine, including public health, sociological and nutritional plans. The members of the State Association should at all times stand behind their committees and support their activities as cleared through the Council. It should be remembered that political and public opposition to proposed medical legislation usually

arise from a lack of knowledge and understanding concerning the principles involved. Doctors should take it upon themselves to bring about a better understanding in their respective counties.

"NUTS"

We are proud of the part played by members of the medical corps at Bastogne, amounting to an American Medical Thermopylæ on Belgian soil. We are proud of Brig. Gen. McAuliffe who, in response to the German ultimatum, immortalized American slang when he unhesitatingly flashed into the teeth of the mongrel mutts, the one stinging word, "Nuts."

Appropriating the word with its glorified meaning, the doctors in Oklahoma want all ambitious politicians who would ruthlessly over-run the patient-doctor-God relationship with their panzer divisions, panting for the plum of regimented medicine, that they say to them emphatically—"Nuts."

CONTROL OF AIR-BORNE INFECTIONS

During the past two or three years air-borne diseases have had a fresh-airing. The stimulus has come through improved methods of study and control and demands arising through war conditions. The fact that nearly one half of reported illness in Army camps is respiratory in origin makes an exhaustive study imperative.

Recent investigations have added much to our existing knowledge of droplet infection through the dispersion of bacteria in the air when the patient coughs or sneezes. Previously it was demonstrated the propulsion of droplets is seldom more than three feet. This has been confirmed by recent studies but of great significance, it has been shown that pathogenic bacteria contaminate the environment by gravitating to the bedclothes, draperies, furniture and floors and that the agitation resulting from bedmaking, sweeping, dusting and even the patient's movements immediately fill the air with the cast off bacteria, greatly increasing the danger of exposure. The relationship of aerial contamination and spread of disease has been fairly well established by the study of cross infections and predominant types in wards and through animal experimentation. Interesting studies dealing with the influence of light, heat and humidity on the survival or life span of bacteria have revealed pertinent facts.

Much additional research is necessary to determine the influence of these factors in the different air-borne pathogens — hemolytic streptococci suspended in saliva and sprayed into a dry room atmosphere may be recovered in viable form 24 hours later. Blankets contaminated with hemolytic strep-

tococci and stored in dry atmosphere may give up these micro-organisms after an interval of four months. These studies made it obvious that control of such air-borne infections must take into consideration these sources of cumulative bacterial reserves which in all probability greatly overshadow the danger from the immediate droplet contamination of the air. The methods employed are: (1) disinfecting the air in closed quarters by the dispersion of propylene or triethylene glycol into the air in the form of vapor; (2) control of dust and lint by the treatment of floors with oil or antiseptic solutions and the use of floor sweeps; (3) the use of an oil emulsion on the bed clothes.

It has been shown that these methods will greatly reduce the number of bacteria in the air and already it is possible to say that the incidence of respiratory infections has been materially reduced. Further study is necessary to determine the full significance of such measures.

MEDICINE AND MARS

Though war has been mechanized and streamlined, it has not run away from medicine. In *The West Virginia Medical Journal*, Norton³ discusses improved methods of disease control and the care of casualties.

In the past, communicable diseases have been "mightier than the sword" but in this war control methods have materially reduced this hazard. The prevention of air-borne infections affords one striking example of control and as Norton says, of another field "consider for instance the delousing of a million and a half persons in Naples to halt a threatened epidemic of typhus. . ."

Case fatality rates for combat casualties have been greatly reduced by efficient first aid and rapid transportation to medical officers at treatment stations or hospitals. Highly trained medical personnel, sanitary discipline, medical supplies, plenty of morphine, plasma, whole blood and chemotherapy have achieved results never obtained in previous wars.

The virtual obliteration of time and space, speeding the patient, casualty or illness, to the site of definitive medical and surgical care has played an important roll.

Facile adaptation of available medical and surgical services to immediate situations with all their variables, including adjustments to terrain and weather, amounts to an important contribution.

The free spirit of voluntary service and individual initiative which carried our civilian doctors into military service has helped to give our men in line of battle the maximum medical advantage often establishing depots for medical service ahead of food and ammunition. No matter how hard civilian doctors

work, they are not making the sacrifices which daily face the one-time civilian doctors now in uniform. God grant that they may return to a warm place in the hearts of their countrymen and not to a cold berth in a medical bureaucracy.

These striking figures are quoted from Norton's article, "some comparisons and contrasts between World War I and World War II. Our total annual death rate per 1,000 has improved as follows: Mexican War, 110; Civil War, 65; Spanish War, 26; World War I, 19 (8.7 exclusive of influenza); World War II, 1943, 5.5 (all disease about 0.6).

"The case fatality rate for battle wounds during World War I was 7.7 per cent; for World War II, 3.1 per cent."

If Mars cannot mar medicine, why should we submit to the proposed devastating plans of the politicians who may wish to perpetuate their positions of power through a regimented medical service for civilian consumption. God save the day.

1. Norton, John W. R., Lt. Col., M.C., Preventive Medicine Service, Office of the Surgeon General, United States Army. The West Virginia Medical Journal, Vol. 40, No. 12, page 382.

MEDICINE ON TRIAL

Strange as it may seem to us, we must admit that in the minds of the masses, medicine is on trial. If we had always been true witnesses of its benefactions, informing the people of its significance and the humane necessity of its uninterrupted course along present lines, the verdict could not be in question.

As it is, we can only bestir ourselves in an effort to establish our worthy cause through a continuation of accepted methods of practice, a wide dissemination of knowledge and the Apostle Paul's plea to the Romans, "Is it lawful for you to scourge a man that is a Roman and uncondemned."

BOOK REVIEWS

SURGERY OF THE HAND. Sterling Bunnell. 734 pages, 597 illustrations. J. B. Lippincott Company. Price \$12.00

To those of us who have had an opportunity to study under Bunnell in his ever popular presentations in the instructional section of the American Academy of Orthopedic Surgeons, this work presents a long awaited and eagerly anticipated treasure. Without doubt, Dr. Bunnell is one of the masters in consideration of treatment of the hand, and this work represents his customary meticulous and painstaking manner of attacking the various problems in this field.

It is, of course, impossible to take up the various sections of this book in detail, as it is, indeed, an encyclopedia of the hand. One which is a well formulated reference book either for one who is particularly interested in the conditions of the hand, or for those who, of necessity, are called upon to treat these conditions.

The early section on phylogeny, while interesting, is not nearly as valuable to the practitioner as the following chapter taking up the various considerations of the normal hand. An analysis of the motion of the various joints of the wrist and hand will, indeed, be an enlightenment to any one who has not been familiar with the author's work in this field. Many of the problems of the hand are greatly simplified by careful study of the purpose and range of motion of the different joints, tendons and ligaments of the hand. Nowhere is his meticulous technique and ever present patience more evidenced than in his discussion of the treatment of injuries to the peripheral nerves, for in his hands it is possible to repair even the small digital nerves to the fingers, a project which many of us would view with alarm. He presents some new concepts of the operative treatment of tendon injuries, particularly emphasizing his technique for fixation of the active tendon end through a removable stainless steel stay suture, which permits much more accurate opposition of the tendon ends without the necessity for large amounts of suture material to maintain fixation. The section on injuries to the hand in general, the description of the technique of cleaning up the hand, and the discussion of the extremely important part played by the original surgeon in restoring the ultimate function of the hand, may well be taken as a bible by those who have occasion to carry out first-aid treatment for a badly mangled hand. Certainly this is a field where very great improvement of technique may well result in marked reduction of disability.

As may be gathered from the previous remarks, this reviewer is deeply impressed by the work of Dr. Bunnell and recommends this book without reservation, and indeed considers it a "must" for any one who attempts to carry out surgery of the hand.—D. H. O'Donoghue, M.D.

TUBERCULOSIS OF THE EAR, NOSE, AND THROAT; INCLUDING THE LARYNX, THE TRACHEA AND THE BRONCHI: Mervin C. Myerson, M. D., Charles C. Thomas Company, Springfield, Illinois. 291 pages. Price \$5.50.

A book of great value not only to the laryngologist and phthisiologist but to the general practitioner as well. Even though tuberculosis of the nose, throat, ear, larynx, trachea and bronchi may require the attention of the specialist, the lesion must be suspected or discovered by the attending physician. In tuberculosis, as in no other disease, the patient must remain under competent general management regardless of special diagnostic and therapeutic needs.

These are the considerations which make this volume a valuable contribution to any doctor's library. The book appears in handy attractive format, in appealing style, exhibiting 17 chapters and 88 illustrations. The latter are well chosen and clearcut, being accompanied by instructive legends. Eight chapters, making up more than one half of the printed matter, are devoted to the larynx. But this is in keeping with its relative importance.

Among the remaining chapters are those dealing with "Tuberculosis of the Trachea and Bronchus" and "The Technique of Bronchoscopy in Tuberculosis" are of great importance to the phthisiologist. The discussions are handled in a modest, straightforward, authoritative fashion which should appeal to all readers.—Lewis J. Moorman, M.D.

Dr. John Abercrombie and Sir Walter Scott

Among his distinguished patients was Sir Walter Scott in his later days, whom he advised to stop writing if he did not wish to kill himself, and whom he bled with good effects.—*Aberdeen Doctors, At Home and Abroad*, page 112. Ella Hill Burton Rodger. William Blackwood and Sons. Edinburgh and London. 1913.

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ASSOCIATION ACTIVITIES

IMPORTANT MEDICAL LEGISLATIVE MEASURES BROUGHT FORTH AT TWENTIETH LEGISLATURE

During the past month, we have attempted to inform the members with the activities of the Association by holding meetings in the Councilor Districts. Meetings were held as follows: December 1, Chickasha, District No. 5; December 2, Hobart, District No. 2; December 8, McAlester, District No. 9; December 9, Durant, District No. 10; December 14, Supply, District No. 1; December 15, Shawnee, District No. 7; December 22, Ponca City, District No. 3; December 29, Vinita, District No. 8; December 29, Tulsa, Board of Trustees.

The following program was presented:

1. Your Association—Dr. C. R. Rountree.
2. Post-War Planning—Dr. Tom Lowry.
3. Prepaid Surgical and Obstetrical Plan—Dr. John F. Burton.
4. The Legislative Program—Dr. V. C. Tisdal.
 - a. Board of Health—Dr. John W. Shackelford.
 - b. Medical Examiner System—Dr. W. Floyd Keller.
 - c. Amendments to Basic Science Law—Dr. V. C. Tisdal or Dr. J. D. Osborn.
 - d. The Medical School Appropriation—Dr. Tom Lowry.

There was a representative attendance at all meetings, and at McAlester, Durant, Supply, Shawnee, Ponca City and Vinita, Legislators were in attendance and participated in the programs and in every instance expressed a willingness to support the legislation so far as possible.

The meetings were open forums and many valuable suggestions were made by the members and the Legislators. These suggestions have been considered and many of them will be incorporated in the program.

In order that every member will understand the legislative program, a brief outline of each measure is presented herewith. It is hoped that every doctor will make it a point to talk it over with his Senator or Representative at home and urge him to give support.

1. A Board of Health

The Constitution provides for such a Board, but the law was set up for a Board of one man—the Commissioner of Health.

The proposed law calls for a Board of seven members serving for seven years—a majority to be licensed Doctors of Medicine and members to be appointed by the Governor for staggered terms.

This Board will select a Doctor of Medicine with Public Health experience to serve at their pleasure, and will make rules and regulations as provided by law. This should remove the Health Department from politics.

Such a Board would be able to remedy many defects in the laws and regulations of the Health Department.

Oklahoma is one of three states without such a Board.

This bill has been prepared by our Attorney and approved by the Attorney General.

2. Medical Examiners System

The Bill proposing a Medical Examiners System for Oklahoma will substitute physicians for Justices of the Peace as official investigators of violent deaths, persons found dead and deaths following abortions.

In addition to County Medical Examiners, there will also be a Chief Medical Examiner with offices and laboratories located at the University of Oklahoma School of Medicine.

The duties of this Chief Examiner will be to assist, on request, the County Medical Examiners in the performance of their duties and also to serve as Professor of Legal Medicine.

3. Certificates of Basic Science

A law providing for the issuance of certificates to the effect that those licensed as physicians, osteopaths and chiropractors at the time of the passage of the Basic Science Law were issued without the holder having taken and passed an examination in the Basic Sciences. The Bill provides for a fee of \$25.00 which is to be used by the Basic Science Board for the purpose of investigating and prosecuting violators of the respective laws covering all healing arts. The fund will be under the Basic Science Law and it is expected that the fees collected will make it possible to hire attorneys and investigators to investigate violations of the law. And eventually the fees accumulated from the registration fees will make it possible to continue to put this investigation procedure on a permanent basis.

4. The Budget of the Medical School.

The Governor has recommended substantial appropriations for the Medical School. This program will be supported by the State Medical Association.

5. Public Health Laws.

Laws submitted for the good of public health

The following quotations are taken from the speech of Governor Robert S. Kerr to the Twentieth Legislature on opening day:

School of Medicine

"In order to meet the greatly increased need for trained physicians and nurses and to enable us better to solve the acute health problem in Oklahoma, I recommend that the facilities of the Medical Department of the University of Oklahoma and for nurses' training of the Medical Department of the University of Oklahoma be substantially increased."

Public Health

"The preservation of public health has long been recognized as one of the first obligations of government.

"Since the outbreak of the war, The Public Health Service has gone far in protecting troops and civilians alike from disease. Measures developed during peacetime and wartime have been put to work on every front, with the result that few serious epidemics have occurred. The health status of the American people has been comparatively good. This contribution to the efficiency of the war effort and to ultimate victory is recognized.

"Now that we are beginning to turn our eyes to the winning of the peace, it is no less important that we have a strong, physically fit population. Civilization will have to be rebuilt on a more enduring basis, and public health will be a vital factor in attaining this goal.

"Through the inevitable necessities of war tens of thousands of our doctors and nurses have been called into Military Service. Many of those will remain there permanently. Most Oklahoma communities have a serious shortage in medical services, and some have almost none at all. Oklahoma has supplied all the doctors and nurses to the Armed Forces that have been required of us and many more. We are intensely proud that we have been able to do this, but the resulting situation greatly emphasizes our needs for increased medical and public health services.

"As to the need for the training of doctors and nurses I have made specific reference and recommendation in another part of this message.

"I remind you that tuberculosis up to November 30, 1944, has killed 145,000 U. S. civilians since Pearl Harbor, a figure which exceeds by more than 20,000 the total number of our fatal casualties in this war for the same period.

"We cannot ignore the rising tide of infectious diseases discovered in the newly liberated countries of

Europe. There is real danger that some of the deadly enemies of mankind which have been pretty well under control for some years past may slip in the back door while we are engaged in the more pressing business of global war.

"We must also be prepared for an invasion of tropical diseases upon the return of our heroic fighting men who have been fighting our battles in the jungles and lowland of the East. We must bring all the ingenuity and resourcefulness we have to bear upon the solution of these problems.

"No criticism is intended here of those who have had the responsibility of protecting public health in Oklahoma, or of those who have ministered to our stricken citizens. They have done magnificently and are entitled to our praise. What is intended is that adequate provision shall be made to meet the greatly increased need.

"I therefore recommend that you make a diligent study of the State's needs in the field of public health and when they are determined, that you provide for them within the State's means and ability.

"Finally I call your attention to the following language in the Oklahoma Constitution, Art. V, Sec. 39: 'The Legislature shall create a Board of Health. . . ' I further call your attention to Title 63, Section 1 of the Oklahoma Statutes of 1941. Said section reads as follows:

"'A State Board of Health to be in charge of one commissioner, to be known as the State Commissioner of Health, is hereby created. Said Commissioner shall be appointed by the Governor (with term co-terminous with that of the Governor) for a term of four years. . . '

"I do not believe that this provision of our Statutes complies either with the letter or the spirit of the Constitutional provision above quoted. I am also of the opinion that a State Board of Public Health composed of at least five members, or whatever number you in your good judgment may find proper, could and would be of great service to the people of Oklahoma.

"Experience demonstrates that a greater program of physician-Public Health cooperation is not only desirable but essential in accomplishing the tasks before us. I am sure that we would secure the services of some of Oklahoma's outstanding doctors on a basis that would be of great and lasting benefit to the people.

"I therefore recommend that you consider the enactment of the necessary legislation to make this possible."

NAVY URGENTLY IN NEED OF PHYSICIANS

The Chief of the Bureau of Medicine and Surgery, Vice Admiral Ross T. McIntire, has recently stated that the Navy is urgently in need of 3,000 additional physicians because of the grave shortage of medical officers due to personnel expansion and intensification of naval operations in the Pacific area.

The State Procurement and Assignment Service Chairman, Dr. W. W. Rucks, Sr, has been requested by the Bureau of Naval Personnel and the local Office of Naval Officer Procurement to assist in securing additional medical officers, and it is Dr Rucks' request that interested physicians contact him with reference to this request in order that individual availability might be determined and applications processed

The Army will fill its future requirements for military physicians from available sources and therefore will not require certification of additional physicians from civilian practice

POSTGRADUATE OKLAHOMA CITY INTERNISTS' ASSOCIATION AND THE REGIONAL MEETING OF THE COLLEGE OF PHYSICIANS FEBRUARY 22-23

February 22-23 are the dates set for the Oklahoma City Internists' Association and the Regional Meeting of the College of Physicians. The states of Oklahoma, Nebraska, Missouri and Kansas will be officially represented, headquarters being at the Biltmore Hotel, Oklahoma City.

On February 22 the Oklahoma City Internists will meet in the auditorium of the University School of Medicine, luncheon to be served at the University Hospital. In the evening, Dr. Ernest Irons, President of the College of Physicians will be the guest speaker at the Oklahoma County Medical Society meeting and buffet supper to be held at the Oklahoma Club.

The following program has been announced for the Washington Birthday Clinic:

- 9:30—Dr. Ray M. Balyeat, Intrinsic Factors in Chronic Asthma.
- 10:15—Dr. C. M. Pounders, Inflammatory Rheumatism.
- 11:00—Dr. A. W. White, Peptic Ulcers.
- 11:45—Dr. Coyne H. Campbell and Dr. Harry Wilkins, Report on Cases of Frontal Lobotomy.
- 12:00—Dr. Hugh Jeter, Leucemia.
- 12:45—Luncheon.
- 2:00—Dr. Bert F. Keltz, Experiences with Thiouracil in the Treatment of Hyperthyroidism.
- 2:45—Dr. Phil M. McNeill, Chest Infections.
- 3:30—Dr. C. J. Fishman and Dr. H. C. Hopps, Clinical Pathological Conference.

This schedule allows thirty minutes for presentation and fifteen minutes for discussion.

On February 23 the Regional Meeting will be held at the Biltmore Hotel with a noon forum luncheon at the Chamber of Commerce. In the evening a banquet will be held at the Biltmore for the attending physicians and guests. Dr. Ernest Irons will speak together with Mr.

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E. R. Loveland, Executive Secretary of the American College of Physicians, Philadelphia, who will speak on the aims of the College.

The following program has been announced:

Dr. G. M. Tice, University of Kansas—The Usual and Unusual in Gastro-Intestinal Radiology.

Dr. Don Carlos Peete, University of Kansas—Rheumatic Fever.

Dr. Harry Alexander, Washington University—Asthma.

Dr. Graham Asher, University of Kansas—The Role of Calcium Metabolism in Circulatory Disease.

Dr. Moise Levy, Governor of Texas for College of Physicians—Peptic Ulcer, Comparative Study of Cases in General and Industrial Hospitals. Dr. L. B. Zeis is co-author.

Colonel Edgar Allen, U. S. Army—Clinical Use of Anti-coagulants.

Dr. J. Harry Murphy, Creighton University, Nebraska—Anterior Poliomyelitis Treatment—Bulbar Type.

Dr. Frederick W. Niehaus, University of Nebraska—Myth of Apex Beat.

Dr. Cecil O. Patterson, Southwestern Medical College of the Southwestern Medical Foundation, Dallas, Texas—The Injection Treatment of Esophageal Varices.

Major Carl Dietrich, Borden General Hospital, Chickasha, Oklahoma—Penicillin.

Dr. Homer A. Ruprecht, Springer Clinic, Tulsa, Oklahoma—Some Observations on Thiouracil.

Dr. R. H. Bayley, University of Oklahoma—Acute and Chronic Local Ventricular Ischemia.

Dr. Henry H. Turner, University of Oklahoma—Clinical Use of Testosterone Propionate.

Major General David N. W. Grant, Air Surgeon, Army Air Force—Unannounced.

Dr. Oliver C. Melsen, Governor of the College for Arkansas—Diagnosis of Hiatus Hernia.

Capt. O. Davis, Commanding Officer of Naval Hospital

at Norman—Rehabilitation Program of the U. S. Navy.

There will be no fee for the scientific program.

AMERICAN MEDICAL ASSOCIATION TO HOLD 1945 ANNUAL SESSION IN PHILADELPHIA JUNE 18 TO 22

The Ninety-Fifth Annual Session of the American Medical Association will be held in Philadelphia June 18 to 22, 1945. The Journal of the Association announces in its November 25 issue. This session was originally scheduled to be held in New York June 11 to 15, but because of untoward conditions growing out of the war emergency it was found that needed facilities would not be available in that city.

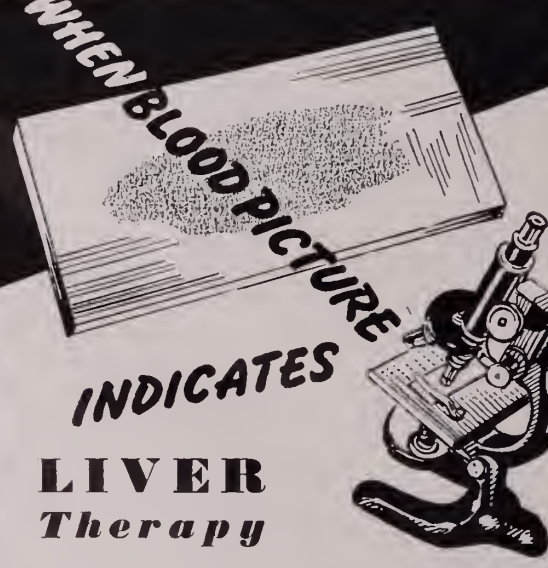
Commenting on the Philadelphia meeting, The Journal says that "Because of the tremendous demands on the hotels for rooms, physicians are asked to cooperate by refraining from making a reservation in more than one hotel, also by limiting their reservations to the minimum amount of space that they need to occupy. Physicians are asked to share accommodations by utilizing a double room with another physician whenever that is convenient.

The medical profession of Pennsylvania and of Philadelphia and all of the groups in Philadelphia concerned in the holding of this session promise to do their utmost to aid the success of the meeting.

NINETEENTH ANNUAL SESSION OF NATIONAL CONFERENCE ON MEDICAL SERVICE SET FOR CHICAGO FEBRUARY 11, 1945

Postwar distribution of medical care will be the theme for the nineteenth annual session of the National

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Conference on Medical Service to be held in the Red Lacquer Room of the Palmer House in Chicago, Sunday, February 11, 1945.

Medical legislation, physical fitness program, rehabilitation of veterans, latest word from the Washington front, relationship between labor and farm groups and medicine are among the topics to be discussed by nationally known speakers who will appear on the program. Also listed on the program will be an open discussion on prepayment medical plans, the principal advantages and defects of both service and indemnity types of insurance being presented. Congressman Arthur L. Miller of Nebraska, author of the Miller Bill to unify certain health services, is to be among the speakers.

Detailed programs of the conference will be ready January 1 and may be obtained through any member of the executive committee or by writing Cleon A. Nafe, M.D., secretary, National Conference on Medical Service, 822 Hume Mansur Building, Indianapolis 4, Indiana.

• OBITUARIES •

John A. Walker, M.D.
1865-1944

Dr. John A. Walker, Shawnee, a prominent physician in Pottawatomie County for more than forty years, died at his home December 25, 1944.

Dr. Walker was born in Paris, Texas, November 10, 1865. His medical preparatory work was done in Paris and at Savoy and Grayson Colleges. He studied medicine in the St. Louis College of Physicians and Surgeons from which he was awarded the degree of Doctor of Medicine in 1897. At this time he came to Oklahoma and became a member of the Indian Territorial Medical Association. At the time of statehood, 1907, Dr. Walker became a member of the Oklahoma State Medical Association, was a charter member and assisted in framing the constitution and by-laws. He attended every annual meeting of the Territorial and State Association up until the year 1944. He was Councilor for the Oklahoma State Medical Association at intervals for more than forty years. Dr. Walker was past-president of the Pottawatomie County Medical Society and was a member of the Board of Censors for many years. He was a member of the staff of the first hospital organization in Shawnee, associated with Dr. J. H. Scott, Dr. R. M. Anderson, Dr. J. M. Byrum and others, also being a member of the Shawnee City Hospital Staff from the beginning of that organization and continued until his death.

Dr. Walker held extensive membership in fraternal orders and was particularly active in the I.O.O.F. of Shawnee, the Masonic Lodge and others. He was a Major in the Medical Corps in the United States Army in World War I. He was a consistent member of the Baptist churches in Shawnee.

Surviving are the Doctor's four sons, Agnew A. Walker, M. D., now practicing medicine in Wewoka; John Knox Walker, Army of the United States; Osmond Walker, stationed at the Navy Base in Corpus Christi and Alwyn Walker of Shawnee.

Dr. Walker will be remembered by hundreds of physicians in Oklahoma for his very keen and consistent interest in the advancement in the practice of medicine

and the improvement in the health welfare in the State of Oklahoma.

Medical School Notes

Dr. D. Bailey Calvin, Associate Dean of the University of Texas School of Medicine, gave a clinical lecture for first year students on October 28, 1944. His subject was: "Plasma Proteins; Their Osmotic Pressure Phenomena."

Five members of the faculty of the School of Medicine attended the 33rd annual meeting of the Oklahoma Academy of Science, held in Stillwater, Oklahoma, December 2, 1944. They were: Dr. Arthur A. Hellbaum, Dr. Joseph M. Thuringer, Dr. Howard C. Hopps, Dr. Allen J. Stanley, and Dr. Mark R. Everett.

Papers were presented by three of the group. Dr. Everett discussed "Phases of Protein Metabolism of Interest in Medicine." Dr. Stanley spoke on "The Shock Producing Factor in Skeletal Muscles," and Dr. Hopps presented a paper entitled "Anoxia and Its Effects on Capillary Permeability."

The annual Medical School Gridiron was held Wednesday evening, December 20. Members of the faculty and clinical staff were burlesqued by the respective classes. Immediately following the program, an all-school dance was held at Blossom Heath.

The Council on Medical Education and Hospitals of the American Medical Association, at its meeting on November 19, 1944, voted to extend its approval to the University of Oklahoma School of X-Ray Technicians.

The students at the University of Oklahoma School of Medicine, under the sponsorship of the recently organized Student Council, on December 9, published the first issue of the Student Newspaper. Mark Johnson, a member of the Junior Class, is editor of this publication. The first issue was very well received, and future issues will be released every two weeks.

Plans for the publication of a Medical School Annual are under way by the Students in the School of Medicine. Raymond Hinshaw, President of the Junior Class, is serving as Editor for the first yearbook to be devoted entirely to the Medical School. The annual will consist of approximately seventy-five pages and will contain pictures of the faculty, students, buildings, student activities, a complete alumni directory, etc. The publication of this annual is also sponsored by the Student Council.

Among the books recently received at the Medical School Library are the following: Bausch & Lomb Optical Company—Human Eye in Anatomical Transparencies. 1944; Hahn, E. F.—Stuttering. 1943; Le Marquand, H. S., and Tozer, F.H.W.—Endocrine Disorders in Childhood and Adolescence, 1943; Lewis, Sir Thomas—Research in medicine and other addresses. 1939; Moore, R. A.—Textbook of Pathology. 1944; Morton, Dudley J.—Manual of Human Cross Section Anatomy. 1944; Mottam, J. C.—Problems of Tumours. 1942; Saphir, Otto—Outline of Tropical Medicine. 1944; Stokes, J. H., et al.—Modern Clinical Syphilis, 3rd Edition. 1944.

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Schering is proud of its part in working with the medical profession to make women's life a little sweeter, a little easier. And for the future, Schering's post-war program is one of research and still more research that will contribute to her welfare.



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★ FIGHTIN' TALK ★

Recently ordered to active duty are: LT. JACK WENDELL MYERS, El Reno; LT. HARREL DON MOSELEY, Oklahoma City; LT. ROBERT WALKER, Enid; LT. WILLIAM ORVILLE DAVIS, Cushing; LT. JOHN BERRY GILBERT, Oklahoma City; LT. CLEVE BELLER, Stigler; Promoted from Lieutenant to Captain, THOMAS ARCHIE TROW, JR., Okemah; JAMES RALPH KENNEDY, Purcell; Promoted from Captain to Major, EDWARD EMMETT SHIRCLIFF, Oklahoma City.

Lt. (jg) VANCE LUCAS, Tulsa, '42 graduate, is a battalion surgeon with the Marine Corps and was wounded by shrapnel while landing on the beach at Saipan but has now recovered and is stationed on Tinian Island. He has been in the Pacific for a year.

MAJOR R. L. MURDOCH, Oklahoma City, has reported to Camp Chaffee, Arkansas, for a new assignment, recently having returned from 15 months service in the China, Burma, India Theater.

Incidentally, the Executive Office received a Christmas Card from Major Murdoch which was sent while he was in the China Burma India Theater, and we note that he certainly had his mind strictly on business as the card was addressed to 210 P-L-A-S-M-A Court! Thanks, Major Murdoch!

CAPTAIN FRED T. PERRY, who practiced at Healdton prior to entering service, is home on a 30-day leave after 18 months of service overseas with the medical corps of the 45th division.

Here is a bit of news from MAJOR HERVEY A. FOERSTER, Oklahoma City, who is in England:

"I am now the surgeon of the Western District. Recently I had occasion to welcome COLONEL REX BOLEND and his hospital to England. He has a good organization and he is the same Rex—busy as heck looking after his men, officers and nurses.

"I recently had a nice visit with CAPTAIN GEORGE BORECKY who is stationed not too far from me.

"I attended Thanksgiving Services while in London at Westminster Abbey and saw Ambassador Winant. It was a very impressive service.

"We over here are anxious to get the war over and come back home."

After a visit at his home in Oklahoma City, MAJOR GILBERT HYROOP left for McClosky General Hospital where he has been transferred from Torney General, Palm Springs, California. At Torney he was Chief of the Plastic Surgery and burn section.

"Next to his head a man needs his hands most," the Major says. "So after we have taken care of his face we turn our attention to his extremities."

The Major tells of one man who came in with his left arm severed below the elbow; his right hand minus all its fingers. Using bone graft, tissue transplantation, nerve repair and tendon sutures, he was built a thumb and a palm so that he could hold a pencil or pen, eat, comb his hair. . . in other words, live an independent existence again.

The Major was high in his praise of the work being done in the field hospitals and the base hospitals. "The men come back to our general hospitals in fine surgical conditions," he said.

LT. COL. JACK F. BURNETT, Oklahoma City, '39 graduate, was decorated by General Claire L. Chennault, 14th AAF Commander, with the Bronze Star for meri-

torious service as Flight Surgeon with a unit in China. Col. Burnett is now in Florida for reassignment.

LT. TURNER BYNUM, of the Marines, formerly of Chickasha, sent Season's Greetings and the following bit of news:

"Have run into and across the paths of many of the fellows from home.

"Spent a very enjoyable couple of days with JOHN-NY BLUE of Guymon on the way out. I am with a Marine Corps Evacuation Hospital and expect to see a good deal of action in the near future."

LT. ALBERT McQUOWN, Stillwater, '41 graduate, is visiting his home following his return from 19 months overseas duty as a Fleet Surgeon for a group of LST ships.

He entered the Navy in the spring of 1943 and was sent to Corpus Christi for training. He then was assigned to the LST ships as a Surgeon and took part in the North African invasion. After that he engaged in the invasion of Sicily, and the two invasions of Italy, Salerno and Anzio. For six months the LST ships were in China, India and Burma where they opened the Akyab front in Burma. Then they were called back to England to take part in the invasion of France.

Since the invasion of France, the ships have been going back and forth between England and France carrying cargo, men, casualties and prisoners. Lt. McQuown stated that he had seen 18 countries during his 19 months overseas.

Word From Major Hubbard Heard on Jap Broadcast

MAJOR RALPH W. HUBBARD, Oklahoma City, was taken prisoner by the Japanese at the fall of Bataan two and a half years ago. Recently a message intercepted in a Japanese propaganda broadcast and forwarded by the United States provost marshal, indicates that the major has been receiving letters, packages and pictures from his wife and other relatives. Major Hubbard is believed to be in Cabanatuan, Philippines.

MAJOR WILLIAM K. ISHMAEL, Oklahoma City, with his wife and family, were recent visitors in Oklahoma City of Dr. and Mrs. Earl D. McBride.

LT. W. C. McCLURE, Oklahoma City, writes as follows from somewhere in the South Pacific:

"Just a line to extend to all Oklahoma 'medicos' my sincere wishes for a Merry Christmas and a Happy New Year. Follow with interest all news in the Journal and County Bulletin and really appreciate the steps you are taking in our behalf.

"Have been with the Marines about 32 months now and no complaints—they're a fine bunch. Don't see many 'Okies' out this way so naturally appreciate all news of their activities—would also like to hear from any of them that can find time to write. DRS. TOM DeVANNEY and GEORGE DAVIS are in this vicinity, and doing a fine job. Will be glad when all can settle down to a normal life. Best wishes for progress in all your endeavors."

CAPTAIN GORDON D. WILLIAMS, Weatherford, sends Season's Greetings from France and for a by-line adds: "Don't cure all our patients while we are gone."

NOTE: Thanks for the nice Christmas Greetings that we received in the Executive Office. Thanks, also, for the nice letters and news items—everyone enjoys them and they get quite worn from much 'passing around'. .J.



FIGHT INFANTILE PARALYSIS


FIGHT INFANTILE PARALYSIS

This plea keynotes the great humanitarian struggle waged unceasingly by the National Foundation for Infantile Paralysis since its inception in 1938 . . . and climaxed each January by an intense public awareness and support campaign.

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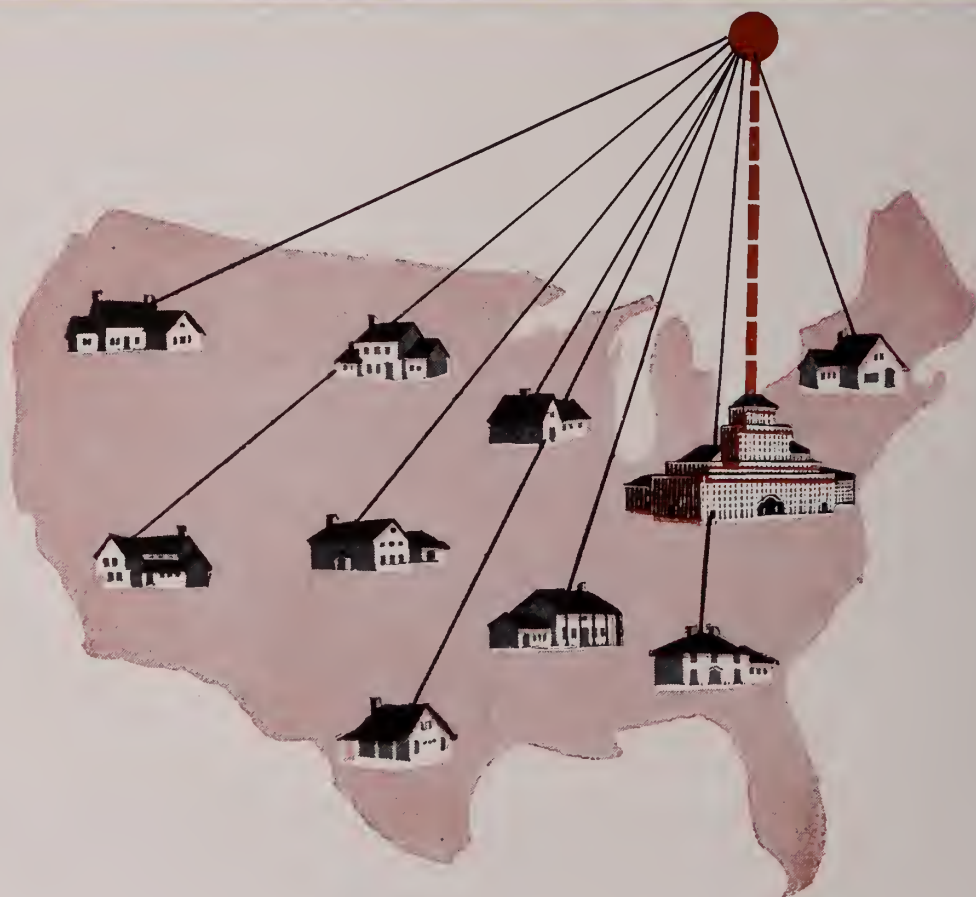


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Of the more than a half-million persons in the United States who suffer from epilepsy, only about 50,000 are in public institutions.¹ Thus, about 90 per cent of the therapy of this disease rests on the shoulders of the physician in private practice.

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1. Tracy Putnam: Convulsive Seizures, p. 4, J.B. Lippincott Co., 1943.

NEWS FROM THE COUNTY SOCIETIES

On Monday, December 15, the Caddo County Medical Society held its annual election of officers at the Anadarko hospital, naming Dr. C. B. Sullivan, Carnegie, president; Dr. E. L. Inman, Apache, vice-president, and Dr. P. H. Anderson, Anadarko, Secretary-Treasurer. It was voted to continue holding monthly joint sessions with Grady County Society with the next meeting scheduled in January at Chickasha.

It was pointed out by Dr. Anderson that the Society, in normal times, carried a membership of 35 doctors; however, at the present time the membership consisted of only 15 doctors, the others serving in the armed forces.

The Carter County Medical Society met on December 9 and elected the following officers: Dr. J. L. Cox, president; Dr. C. A. Johnson, vice-president; Dr. H. A. Higgins, re-elected as secretary-treasurer; Delegates to the state convention: Dr. C. A. Johnson and Dr. F. W. Boadway, with alternates Dr. Walter Hardy and Dr. Walter Johnson.

A committee was named to draft a new constitution and by-laws for the Society. It is composed of Dr. Higgins, Dr. Veazey and Dr. C. A. Johnson.

The meeting was attended by most of the physicians in the County and was a joint session with the staff of the sanitarium.

The election of officers of the Garvin County Medical Society was held at a meeting on December 20 in the Chamber of Commerce room at Pauls Valley. The following were elected: M.E. Robberson, president; A. H. Shi, vice-president; John R. Callaway, secretary-treasurer; M.E. Robberson, Jr., delegates; G. L. Johnson, alternate; E. T. Shirley, censor.

The meeting adjourned to the next regular meeting in January.

Dr. Grady Mathews of the State Health Department was the principal speaker at the December 14 meeting of the Okmulgee County Medical Society meeting. Other speakers included: Dr. L. M. Peter, Okmulgee county health officer; Dr. J. T. Bell, Oklahoma City, and Dr. F. R. Hassler.

The following officers for the coming year were elected: W. M. Haynes, president; H. L. Rains, vice-president; J. C. Matheny, secretary-treasurer; G. Y. McKinney, censor.

Dr. Haskell Smith, Stillwater, was named president of the Payne County Medical Society at the December meeting. Other officers for 1945 include: Dr. H. C. Manning, Cushing, vice-president, and Dr. L. E. Silverthorn, Stillwater, secretary-treasurer.

The Pottawatomie County Medical Society reports the following officers elected for the year 1945: Dr. Charles W. Haygood, president; Dr. W. B. Mullins, vice-president; Dr. Clinton Gallaher, secretary-treasurer; Dr. E. E. Rice, editor of the Bulletin, and Dr. C. C. Young, business manager of the Bulletin; Board of Censors, Dr.

A. C. McFarling, 1947; Dr. M. A. Baker, 1946, and Dr. W. M. Gallaher, 1945. Board of Trustees, Dr. Charles W. Haygood, Dr. Clinton Gallaher, Dr. J. M. Byrum. Executive Committee: Dr. Charles W. Haygood, Dr. W. B. Mullins, Dr. Clinton Gallaher, Delegates and Alternates; Dr. E. E. Rice, 1945-46; Dr. G. S. Baxter, alternate; Dr. W. M. Gallaher, 1944-45, Dr. C. C. Young, alternate.

The Pottawatomie County Medical Society sponsored a meeting of the Seventh Council District on Friday, December 15, 1944. Forty-two doctors and others were present. The purpose of the meeting was the discussion of the legislative program of the Oklahoma State Medical Association and six legislators were present, including Tom Anglin of Holdenville, Al Nichols of Wewoka, Meade Norton of Shawnee.

Dr. John C. Perry was named president-elect of the Tulsa County Medical Society at the annual business meeting held in December. Doctor Perry will serve in 1946, succeeding the incoming president, Dr. Homer A. Ruprecht, who was elected last year to serve during 1945. Dr. Ralph A. McGill is retiring president and becomes a trustee of the Society.

Other officers elected include: Dr. R. Q. Atchley, vice-president; Dr. E. O. Johnson, secretary-treasurer; Dr. M. V. Stanley, delegate; Dr. V. K. Allen, censor; Mr. Jack Spears, executive secretary.

At the meeting of the Washington-Nowata County Medical Society, Dr. J. V. Athey who, for the past 20 consecutive years has served as secretary-treasurer of the Society, was named president. Dr. S. A. Land of Nowata was named as secretary-treasurer and Dr. R. C. Gentry was elected vice-president. Other officers elected were: Dr. Keiffer Davis of Nowata, trustee; Dr. J. P. Vansant of Dewey, censor; Dr. L. D. Hudson and Dr. Gree, delegates from Washington County, with Dr. H. C. Weber and Dr. H. G. Crawford as alternates. Dr. Davis was elected delegate from Nowata County and Dr. Land was named alternate.

After the election of officers Dr. E. E. Beechwood gave a review of the Rh Factor and its relation to obstetrics. A general discussion was held afterward.

The Woods County Medical Society elected officers at its November meeting which was held in Alva. A steak dinner was served for the doctors, their wives and guests. Dr. John F. Burton of Oklahoma City spoke on the Prepaid Medical and Surgical Plan and read a paper on The Modern Treatment of Burns. Dr. Charles R. Rountree then read a paper on Treatment of Ankle Fractures which was illustrated by lantern slides.

The following officers were elected: Dr. O. E. Templin, president; Dr. Wm. F. LaFon, vice-president; Dr. I. F. Stephenson, secretary-treasurer; Dr. D. B. Ensor, delegate; Dr. W. F. LaFon, alternate; Dr. D. B. Ensor, censor (three years); Dr. W. F. LaFon (held over) censor (two years); Dr. C. A. Traverse (held over) censor (one year).



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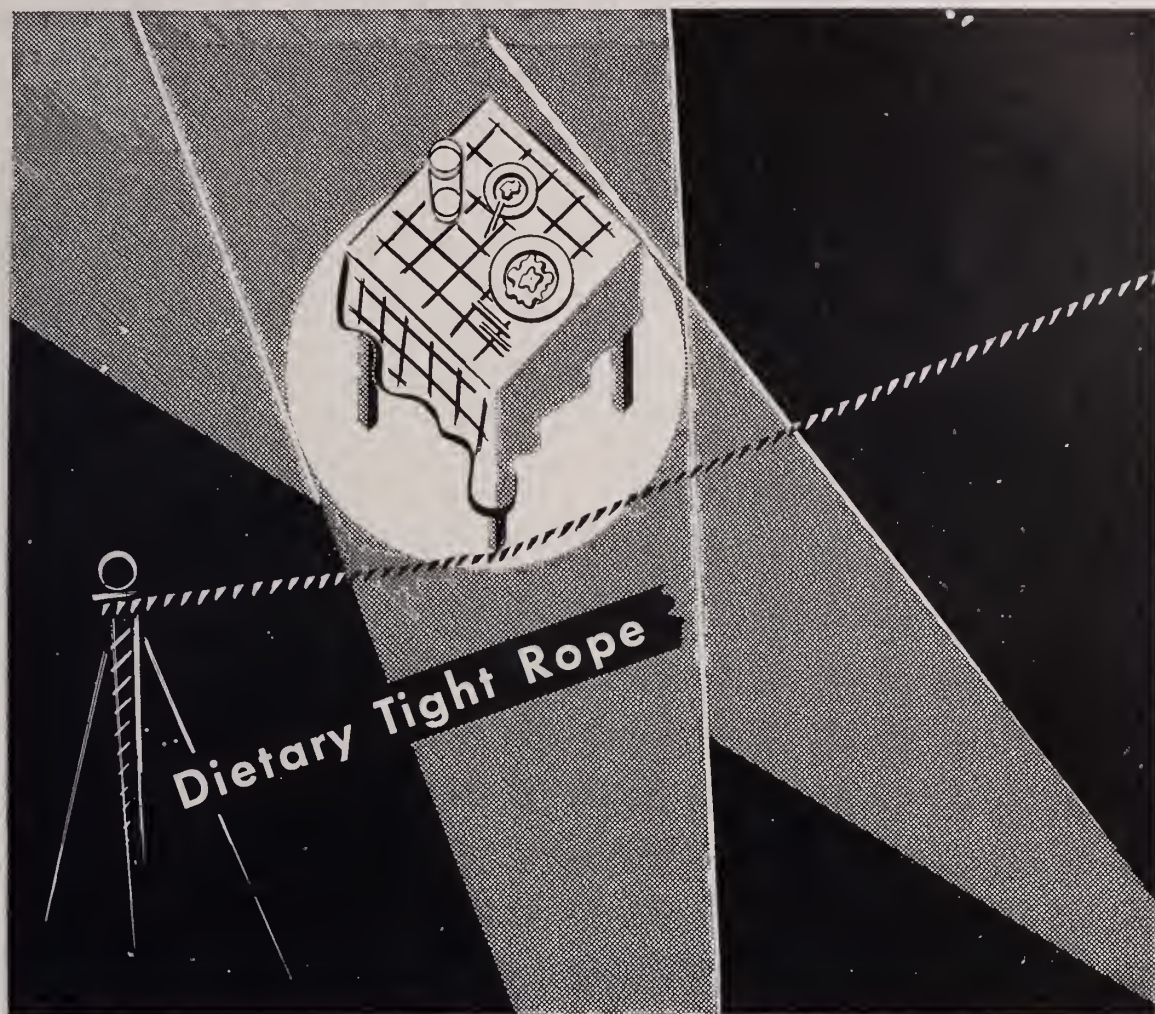
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REPORT PENICILLIN X EFFECTIVE IN TREATMENT OF GONORRHEA

A single Injection of a New Variety of the Drug Cured Sixty-Four of Sixty-Eight Patients Treated, Four Washington Investigators Say

The successful treatment of gonorrhea with a single injection of penicillin X, a new variety of the drug, is reported in The Journal of The American Medical Association for December 16 by Henry Welch, Ph.D., Lawrence E. Putnam, M.D., William A. Randell, Ph.D., and Robert P. Herwick, M.D., Washington, D.C.

As the four investigators point out, this parallels a recent report that gonorrhea had been successfully treated with single injections of regular or commercial penicillin incorporated in a beeswax-peanut oil base. In their study the Washington men treated 68 patients with gonorrhea, most of whom were sulfonamide resistant, by a single intramuscular injection of 25,000 units of penicillin X.

"The group consisted," they say, "of 35 males and 33 females. Our criterion of cure was three negative cultures obtained one, three and five days after treatment had been completed, although in some cases, because of menses or other factors, cultures were taken at greater intervals and over a longer period of time.

"Sixty-four patients, or approximately 94 per cent of those treated, were cured. For comparative purposes a group of 58 patients with gonorrhea (31 males and 27 females) were treated with a single intramuscular injection of 25,000 units of commercial penicillin. Using the same criterion, 37 patients, or approximately 64 per cent of those treated, were cured. It is of interest that 3 of the patients in whom we failed to obtain a cure with commercial penicillin were cured by a subsequent treatment with a single injection of 25,000 units of penicillin X. . ."

Studies of the blood concentrations of the drug were made on 7 patients treated with penicillin X and on 8 treated with commercial penicillin. These concentrations were determined one-half hour and two hours following intramuscular injections. During the first two hours after treatment, a consistently higher concentration of penicillin X was maintained in the blood. Studies of the excretion of the drug in the urine were made over a period of eight hours on 9 patients, 4 treated with penicillin X and 5 with commercial penicillin. After eight hours the total excretion of penicillin X was 71 per cent as compared with 80 per cent of commercial penicillin.

"Further studies," the four men say, "are in progress using larger doses of penicillin X in a single intramuscular injection to determine its efficacy and rate of excretion at higher levels.

"Although the number of cases reported here is small, if further work substantiates the fact that a large proportion of cases of gonorrhea can be cured with a single intramuscular injection of penicillin X, the public health control of this disease, which has been materially affected by the use of commercial penicillin, will be further facilitated."

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Post-Surgical Starvation

with its wastage of body tissues, especially tissue and plasma protein, "begins almost at once after protein is omitted from the diet." Hence it is recommended* that meat and other protein foods be added to the diet as soon as possible after surgery. Meat is not only rich in protein, but its protein is of highest quality, able to meet every protein need.

*"Surgeons are accustomed to attribute most of the postoperative weakness or asthenia to the operative procedure without realizing that much of it may actually be due to starvation, particularly deprivation of protein . . . the fall in plasma albumin begins with the very onset of a protein deficient diet . . . Solid food, as eggs and meat, should be added as soon as possible. Most postoperative patients can eat food much earlier than they are usually permitted to." Elman, R.: Acute Starvation Following Operation or Injury: With Special Reference to Caloric and Protein Needs, Ann. Surg. 120:350-361 (Sept.) 1944.



The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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MEDICAL ABSTRACTS

"INJURY TO THE EARS AMONG BATTLE CASUALTIES OF THE WESTERN DESERT." E. G. Collins. *The Journal of Laryngology and Otology*, London, pp. 1-15, January 1944, Volume 59.

Evidence is gradually accumulating that the increasing blast pressure from the explosives now in use affect the ears in a far higher percentage than formerly. The author's clinical investigation covers a period of seven months from November, 1941, up to the fall of Tobruk on June 20, 1942. The total number of battle casualties examined was 885; the number of men who showed injury to their ears was 183, which is about 20 per cent. In many of them the injury to the ear was trivial compared with their other wounds. These other wounds were on the upper part of the body in 76 per cent of the cases, but even those whose bodies were wounded below the chest often had severe ear injuries.

Soldiers riding in a tank were often free of concussion deafness though their tank was hit by gun-fire. Yet, if a shell penetrated the tank and exploded inside, a high proportion of those who were not killed outright sustained aural injury.

The statement is sometimes made that rupture of the tympanic membrane protects the inner ear against concussion and that the person who sustains a rupture of his drum head is likely to be left with little residual deafness. The author's opinion is that the inner-ear damage occurs before any rupture of the tympanic membrane can take place and that the severity of the cochlear damage is directly related to the intensity of the

blast pressure. It is unlikely that the intrinsic muscles of the middle ear can exert any considerable function in protecting the middle or internal ear against blast.

Whether the tympanic membrane ruptures or not depends mainly on the relation of the blast pressure wave to the axis of the external auditory meatus; anyhow, this rupture is relatively unimportant were it not for the fact that infection of the middle ear is liable to supervene. Rupture can develop from quite a low blast pressure, which would not cause inner ear damage, yet the bleeding and pain may send the injured to the otologist; while with a rather severe inner ear damage may not cause much physical discomfort, and the patient may not seek the doctor's office. This fact is liable to cause a distorted picture of the general situation of ear injuries.

Blast injury to the external ear is of importance because of the scorching and impregnation of the skin with dirt and cordite. This may cause considerable serous discharge which may trickle into the external auditory meatus and infect the middle ear through a rupture of the tympanic membrane. This injury was most frequently seen in blast from a land mine or hand grenade. In some patients the external ear became considerably swollen and inflamed and in two patients a perichondritis of the external ear developed.

Blast injury of the tympanic membrane may vary from small petechial hemorrhages to almost total destruction of the membrane proper. In 20 patients the former condition was observed but only one case was seen, where a sailor had been blown off a torpedoed ship

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into the sea and the middle ear had become infected. The perforation is of a punched-out appearance, but if the tympanic membrane is examined within a very short time of the injury, the perforation frequently assumes a more slit-like form. If the edges of the perforation show eversion, it indicates that it is the suction wave of blast which is responsible for the ear injury. The author believes that the aural trauma usually is caused by the positive phase of blast. The injury was bilateral in 53 out of 162 cases. Multiple perforations were caused occasionally. In one patient there was a cluster of four perforations in a rosette form around the umbo. Out of 218 perforations, 71 were anterior, 86 posterior, 41 inferior, and 20 central. Only one perforation of Shrapnell's membrane was seen, and even this was doubtful whether it was of traumatic origin. If no infection of the middle ear supervenes, the vast majority of the perforation is not too large. The average time for healing is a month to six weeks, but repeated trauma will delay this even as long as half a year. The size of perforation has no direct relation to the weight of the missile: land mine explosions may cause larger perforations than the explosion of the heaviest bombs.

Blast injury of the middle ear may be manifested by hemorrhage. This may be due to rupture of the tensor tympani or stapedius muscle. Though the tympanic membrane may be intact in some of these cases, there is usually a rupture or even total destruction of the ear drum. Infection is by far the most frequent cause of damage to the middle ear as the result of blast. Fifty-seven of 218 traumatic perforations had middle-ear infection. The possible causes of infection are various. Foreign material and organisms may be blown into the middle ear by the blast. This happens in about 75 per cent of the cases. Infection may be also caused by an otitis externa which the patient had had before his injury. Faulty treatment by the doctor is another cause: instillation of ear drops or syringing. Nasopharyngeal sepsis is another cause of middle ear infection. Usually the infection of the middle ear was of low virulence in the cases observed, and only in three was a mastoid operation necessary. If the aural discharge is treated early, the infection will clear up, but if left untreated, it becomes a chronic suppurative otitis media for a life time. Even though the infection subsides, there is a tendency for persistence of the perforation or delayed healing with scarring of the ear drum head, chalk deposits and middle ear deafness caused by the adhesions.

In blast injury to the auditory labyrinth the probable pathological damage is a lesion of that part of the organ of Corti which is situated near the basal coil of the cochlea. Hemorrhage into the endolymph and also into the internal auditory meatus have been recorded. The result will be a high tone loss. It is still a question how much of this deafness is of psychological origin. Whether such an injury to the cochlea may develop a progressive and early senile deafness is also undecided.

The vestibular labyrinth is damaged by blast far more frequently than is imagined. After the injury of explosion there will frequently be seen some spontaneous nystagmus and rombergism most marked to the side of the injured ear. Usually these labyrinthine symptoms disappear within two or three days.

Prophylaxis may be directed against the explosion and against the disabling sequelae of blast. Cotton wool gives a reasonably good protection from blast; steel helmets can be designed so that they protect the ears (German and American models). All battle casualties evacuated to base should have their ears examined by an otologist, and if the tympanic membrane is ruptured, the infection should be prevented. Blast injury of the external ear is treated as any other wound (sulfanilamide). Blast injury of the middle ear can be treated on the ordinary lines of otitis media. For concussion deafness the best is rest and avoidance of repeated trauma; if tinnitus is troublesome, luminal is probably the most effective remedy.—M.D.H., M.D.

"STABILIZATION OPERATIONS OF THE FOOT." A. K. Basu. Calcutta Medical Journal, Vol. xxxix No. 9. 1942.



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The author describes and summarizes six types of operation for stabilization of the foot to produce a firm, painless foot, suitable for weight-bearing and progression. Indications for their employment are in postparalytic flail-foot, in neglected congenital talipes, in peroneal-nerve injuries, and in fractures of the talus or calcaneum. The operations described are Whitman's astragalectomy, Naughton Dunn's triple arthrodesis, Lambrinudi's operation, subastragalar arthrodesis, Campbell's operation for paralytic foot-drop, and Putti's operation for paralytic calcaneal deformities. The author reports five cases in which he has used one or another of these techniques, and discusses postoperative treatment and comparative results.—E.D.M., M.D.

"THE PROGNOSTIC VALUE OF PAPILLO-RETINITIS IN ARTERIAL HYPERTENSION." Riser, Plangues, et al. *La Presse Medicale, Paris.* Vol. 52, pp. 113-114. April, 1944.

The existence of a retinopathy with edema, papillary or peripapillary hemorrhages in a patient with high blood pressure is considered by many as very serious, regardless whether the arterial hypertension is caused by primary nephritis, or by other pathogenetic mechanism. According to American statistics, after the apparition of marked papillary edema, retinal exudates and hemorrhages the patient's expectation of life cannot be more than one or two years, or even less.

The authors also take the sign of hypertensive retinopathy very seriously, regardless of the pathogenesis of hypertension. Yet, even with this very serious prognostic sign, there are a few exceptions. The authors mention three cases. In the first patient, suffering from primary malignant hypertension, the first attack of hypertensive papilloretinitis was followed by a seven-year remission; then, a new attack of papilloretinitis developed, and was soon followed by death of the patient. In another case, a mild case of primary hypertension, there was a very serious attack of papilloretinitis, after which the patient showed signs of improvement, and has been in good health for about five years. In the third case also, the patient is still alive five years after the development of the infaust prognostic sign of papilloretinitis.

In all these cases there was marked retinopathy with large edema, papillary and peripapillary exudates, but the hemorrhage was either minimal or absent. Retinal edema alone, or with papilledema is also seen in hypertensive patients. Its significance is not as clear as that of retinopathia with exudates of the posterior pole of the eye; its consequences are certainly not very serious, though it is an alarming sign.

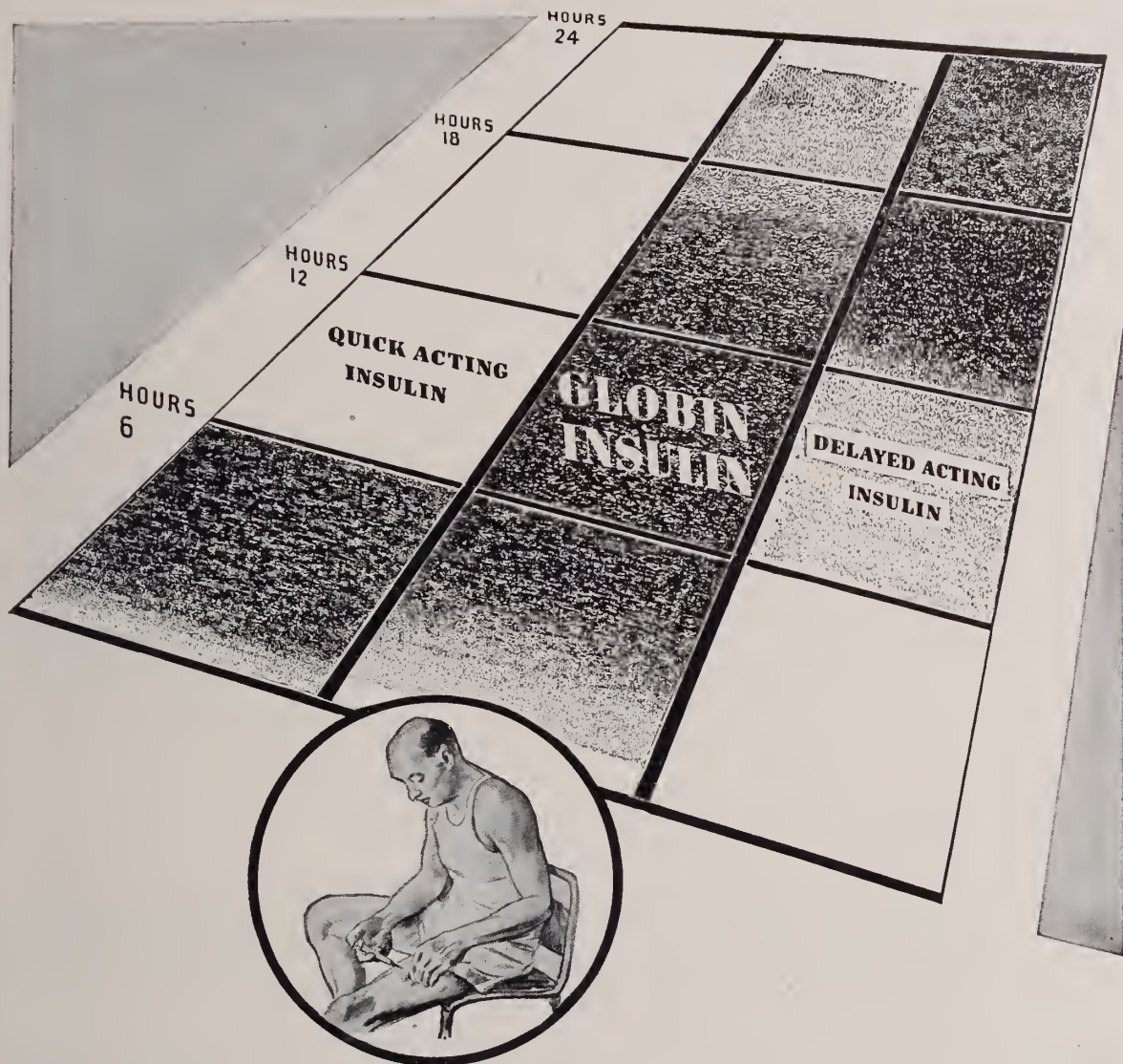
In the cases described by the authors the papilloretinitis, which may be also called dedmatous and exudative retinopathy, was not accompanied by cardio-renal insufficiency or cerebro-meningeal edema, or any focal lesion in the brain. The edema and exudate of the retina was entirely the result of local vascular disorder. This type of retinopathy differs from the very grave retinal disease seen as a complication or the terminal stage of malignant hypertension, where it is always an indication of early death.

The observations of the authors show that isolated papilloretinitis, that is, a papilloretinitis without other signs of arterial hypertension has little prognostic significance.—M.D.H., M.D.

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KEY TO ABSTRACTORS

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COUNTY	PRESIDENT	SECRETARY	MEETING TIME
Alfalfa.....			Last Tues. each Second Month
Atoka-Coal.....	C. D. Dale, Atoka	J. S. Fulton, Atoka	
Beckham.....	G. H. Stagner, Erick	O. C. Standifer, Elk City	Second Tuesday
Blaine.....	Virginia Curtin, Watonga	W. F. Griffin, Watonga	
Bryan.....			Second Tuesday
Caddo.....	C. B. Sullivan, Carnegie	P. H. Anderson, Anadarko	Subject to call
Canadian.....			
Carter.....	J. L. Cox, Ardmore	H. A. Higgins, Ardmore	First Tuesday
Cherokee.....			
Choctaw.....			
Cleveland.....			Thursday nights
Comanche.....			
Cotton.....			Third Friday
Craig.....			
Creek.....	C. R. McDonald, Mannford	Philip G. Joseph, Sapulpa	Third Thursday
Custer.....	T. A. Boyd, Weatherford	W. H. Smith, Clinton	Fourth Thursday
Garfield.....			Wednesday before
Garvin.....	Marvin E. Robberson, Wynnewood	John R. Callaway, Pauls Valley	Third Thursday
Grady.....			Third Thursday
Grant.....			
Greer.....	R. W. Lewis, Granite	J. B. Hollis, Mangum	
Harmon.....	W. G. Husband, Hollis	R. H. Lynch, Hollis	First Wednesday
Haskell.....			
Hughes.....	H. A. Howell, Holdenville	Imogene Mayfield, Holdenville	First Friday
Jackson.....	C. G. Spears, Altus	E. A. Abernethy, Altus	Last Monday
Jefferson.....			Second Monday
Kay.....			Second Thursday
Kingfisher.....			
Kiowa.....			
LeFlore.....			
Lincoln.....			First Wednesday
Logan.....			Last Tuesday
Marshall.....			
Mayes.....			
McClain.....			
McCurtain.....			Fourth Tuesday
McIntosh.....			First Thursday
Muskogee-Sequoyah			
Wagoner.....	H. A. Scott, Muskogee	D. Evelyn Miller, Muskogee	First Monday
Noble.....	D. F. Coldiron, Perry	Jess W. Driver, Perry	
Okfuskee.....	W. P. Jenkins, Okemah	M. L. Whitney, Okemah	Second Monday
Oklahoma.....	Gregory E. Stanbro, Okla. City	Ben H. Nicholson, Okla. City	Fourth Tuesday
Okmulgee.....	W. M. Haynes, Henryetta	J. C. Matheney, Okmulgee	Second Monday
Osage.....			Second Monday
Ottawa.....	P. J. Cunningham, Miami	L. P. Hetherington, Miami	Third Thursday
Pawnee.....			
Payne.....	Haskell Smith, Stillwater	L. E. Silverthorn, Stillwater	Third Thursday
Pittsburg.....			Third Friday
Pontotoc.....			First Wednesday
Pottawatomie.....	Chas. W. Haygood, Shawnee	Clinton Gallaher, Shawnee	First and Third Saturday
Pushmataha.....	John S. Lawson, Clayton	B. M. Huckabay, Antlers	First Monday
Rogers.....			Third Wednesday
Seminole.....			
Stephens.....		W. E. Ivy, Duncan	
Texas.....			
Tillman.....			
Tulsa.....	H. A. Ruprecht, Tulsa	E. O. Johnson, Tulsa	Second and Fourth Monday
Washington-Nowata.....	J. V. Athey, Bartlesville	S. A. Lang, Nowata	Second Wednesday
Washita.....			
Woods.....	O. E. Templin, Alva	I. F. Stephenson, Alva	Last Tuesday
Woodward.....	Roy Newman, Shattuck	C. W. Tedrowe, Woodward	Odd Months Second Thursday

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Corneal Ulcers*

MARVIN D. HENLEY, M.D.

TULSA, OKLAHOMA

Among the eye affections, ulceration of the cornea is one of great practical importance both to the specialist and to the general practitioner. Its frequent association with eye injuries is amply shown by statistics, and one wonders if such ulcers are not often due to carelessness or ignorance. Adequate vision is so dependent upon a healthy, clear cornea that a discussion of the dangers of corneal ulcers seems to be very timely. This is particularly true at this time since the hazards are multiplied by mass employment in war industry.

The cornea is the most exposed part of the eyeball. With the exception of the lid reflex, there is almost nothing to protect it from external dangers. Anatomically, it is a membrane of rather simple structure. On a vertical or cross section, the outside layer consists of five or six rows of superimposed epithelial cells; below this is the homogenous cell-less layer of Bowman's membrane, which is over the corneal stroma or parenchyma of elastic and connective tissue fibers and cells. This is followed by a thin, homogenous layer, the so-called Descemet's membrane to which, toward the anterior chamber, is attached a layer of endothelial cells. Developmentally, the external epithelial layer and Bowman's membrane may be considered as belonging to the conjunctiva; the parenchyma is in kinship with the sclera, while Descemet's membrane and the inner endothelial layer are related to the uvea. Such embryological relations will explain the participation of the various corneal parts, once, in diseases of the conjunctiva, and, once, in affections of the

uveal segment of the eye. The cornea is a rather thin membrane, and it is not hard work for an ulcer to penetrate the 350 to 400 microns of corneal layers and lead to a perforation. Since there are no blood vessels and no lymphatics in the cornea, its nourishment is by the very primitive means of imbibition and fluid diffusion, whatever fluid may come from the limbal loops of conjunctival and ciliary vessels. No wonder that a regular fluid exchange might be easily disturbed, and cloudiness may be produced even by a long lasting lavage of the conjunctival sac with an osmotic fluids.

Structurally, though the external epithelial layer, which is only about 40 microns in thickness, is a rather good protection against injury and infection; Bowman's membrane and the corneal parenchyma itself have very little resistance. The lack of blood vessels and the sluggish metabolism of the corneal parenchyma also explains that the cornea is almost a foreign body in the human organism as far as general immunological processes are concerned. Immune bodies produced by various mechanisms will hardly be able to reach the cornea by the bloodstream in order to increase its resistance against infection. For the same reason, neither are we able to protect the cornea by active or passive immunization of the body.

With this preliminary consideration of the helplessness of the cornea, let us now follow the evolution of a corneal ulcer. Ulcer is not synonymous with erosion or with epithelial defect, though lack of epithelial covering is a characteristic feature of every ulcer. The erosion has to become infected before it may be called a corneal ulcer. It is sometimes the

*Delivered Tuesday, April 25, 1944, before the Section on Eye, Ear, Nose and Throat at the Annual State Meeting, Tulsa.

other way around: the cornea is first infected, and the epithelial defect secondarily develops. Two types of corneal ulceration can be distinguished; (a) one which develops from a primary external lesion of the cornea, after loss or necrosis of the epithelium; such is the pneumococcic infection and the resulting *ulcus serpens*; (b) one which develops from a primary subepithelial or parenchymatous lesion of the cornea as seen in tuberculous allergy and the resulting *ulcus scrophulosorum*. An exogenous ulceration, of course, attacks an immunologically unprepared cornea, which attempts protection by a rather vehement acute defense reaction, while endogenous ulceration appears as a more or less slow process.

Primary external defects, or primary epithelial loss may develop from injury, from disorders of the trigeminal nerve, and in connection with many tropic disorders of the cornea; but defects and even deeper parenchymatous losses of substance do exist without any inflammatory reaction of the eye. Only when in the denuded parenchyma an infiltrative process becomes visible in the form of grayish-white spots is the defect properly called an ulcer. The pathological basis of these infiltrations is the immigration of phagocytes that congregate at the bottom or at the edges of the epithelial defect.

Exogenous ulcers may therefore develop secondarily in a great number of corneal affections as well as in several conjunctival diseases such as trachoma. It may also happen that a healthy cornea is attacked by bacteria; the toxins of certain bacteria may liquefy the corneal tissue, which in turn becomes a culture medium for the further development of new bacterial colonies. The corneal reaction and the type of the ulcer will depend on the virulence of the attacking germs and on the individual corneal resistance.

The source of infecting bacteria is manyfold. Thus, many bacteria can be found even in the normal conjunctival sac, especially in the eyes of workmen. Suppuration of the lacrimal apparatus is a common source of infection of many corneal injuries. The type of infecting bacterium can be identified by proper microscopic examination of smears taken from the edges of corneal ulcers. All sorts of bacteria are found as causes of corneal ulceration. Bencine found *Escherechia paracoli*¹; Sedan found *Salmonella paratyphi A*²⁷; others saw ulcers caused by the bacillus of Petit^{10,15}. Meyer described cases of corneal ulcer caused by the virus of lymphogranuloma venereum²¹. Sometimes the source of bacteria may be an infected sinus⁶, or the foreign body which caused the original cor-

neal injury. Pyocyanous ulcerations frequently develop in the eyes of harvesters, the bacterium being carried into the eye with the dust of threshing. Perhaps the infective organism is a fungus such as *Candida*, *Phenolcladium*, *Glenospora* or other pathogenic fungi^{24,32}.

Rhodes examined 120 cases of hypopyon ulcer, and found that 21.6 per cent of the ulcers were sterile; 32.4 per cent were caused by diphtheroid bacteria; 12.5 per cent by *Staphylococcus albus*; 11.6 per cent by *Pneumococcus*; 7.5 per cent by *Staphylococcus* combined with diphtheroids; 3.3 per cent by *Staphylococcus aureus*; 3.3 per cent by *Morax's diplobacillus*; 3.3 per cent by anthracoid bacteria; 2.5 per cent by *Streptococcus viridans*; 0.8 per cent by *Streptococcus hemolyticus*.

The cornea may be lowered in resistance by previous general disease such as, acute infectious diseases, syphilis, or metabolic diseases such as diabetes mellitus, in which even bilateral symmetrical ulcerations have been observed. There are certain occupations in which corneal ulceration is more frequent. Dickson surveyed a total of 350 cases, and found that 250 or 66.8 per cent occurred in coal miners⁸, and the rest in engineers, housewives, laborers, farmers, and railway men. In 1943, Brown described three cases of pyocyanous ulcer, all of the patients being railway men⁴.

Exogenous ulcers tend to progress. They show suppurative infiltration, and, when leukocytes come in great abundance from the iris to the aqueous, a hypopyon will be seen, and the ulcer is called a hypopyon ulcer. By the hypopyon, the iris and other uveal tissue becomes irritated, and the picture of ciliary injection develops. Since the development of the ulcer is rather rapid there is no time for corneal vascularization.

In endogenous ulceration or exulceration first an infiltration is seen in the corneal parenchyma, which is caused by allergy to bacterial toxins or by degenerative deposits in the cornea such as calcium, fat, hyalin, etc. Occasionally, infective germs may be carried into the parenchyma by the bloodstream. The corneal tissue becomes affected before any ulcer can be seen. The exulceration itself follows a slow evolution of the disease. The signs of local defense reaction are slight: slight iritis, little or no ciliary injection, practically never a hypopyon, and very slow progression. On the other hand, there is much time for the development of corneal vascularization. The tissue necrosis may gradually reach the surface epithelium, and there we have the ulcer, with a usually sterile ground, with indefinite edges, in an almost clear cornea.

Extension of tissue necrosis makes the cornea very thin, and, under the normal eye tension, the thin ulcerating residue of the cornea may bulge out at the surface of the ulcer in the form of a keratocele. If the keratocele perforates, there is an established corneal fistula through which infective germs may enter the innermost structures of the eye and may bring on panophthalmitis. Meanwhile there may be various complications such as prolapse of the iris, synechia of iris, hernia of the vitreous and loss of lens²², expulsive hemorrhage, episcleritis, and even sympathetic ophthalmia¹⁶.

Under the effect of our therapeutical measures an established ulcer begins to heal: first, the infiltration is less and less; then, the ground of the ulcer becomes clear; new epithelium will form and grow over the ulcer from its edges. There is now an epithel-covered dell in place of the ulcer. Sooner or later, the dell is brought up to the level of the normal cornea by subepithelial growth of the connective tissue parenchyma, thus re-establishing the original thickness of the cornea, but the cornea is now neither smooth nor transparent, and at the site of the ulcer the final result is opacity and a highly irregular astigmatism, since only a few types of ulcer do not penetrate below Bowman's membrane. Such superficial ulcers may heal spontaneously, and without a scarry trace.

This is the general evolution of corneal ulcers, but there are many variations in this pathogenetic process according to the nature of the infective organism.

Pneumococci are mostly responsible for the so-called *ulcus cornea serpens* or hypokeratitis. Most often Type IV of the *Pneumococcus* can be discovered; in 30 per cent of the pneumococcal cases Type III have been found. The other types are almost never seen in eye affections. The source of these pneumococci may be a chronic conjunctivitis or dacryocystitis. The pneumococcus itself cannot attack the cornea; it infects only an accidentally injured epithelium. Miners, stone breakers, harvesters, lumbermen, and farmers are often exposed to such slight epithelial erosions of the cornea, hence the pneumococcal ulcer most often occurs in their eyes. The early stage of the infection begins with a whitish infiltration of the denuded surface, and with slight edema of the cornea. The ulcer is mostly in the central area of the cornea, but it extends from there in all directions. The iris soon becomes irritated, a plastic iritis develops, leukocytes enter the anterior chamber, and posterior synechia may be seen. The diagnosis of pneumococcal ulcer can be made from smears and from a careful search after the preliminary injury of the eye. The prognosis of such

ulcers is not favorable, especially in elderly people. Even after apparent healing, one has to count on fresh progression of the ulceration caused by bacteria which remain embedded below the new epithelium. Since the ulceration is mostly central, a final leukoma and the accompanying astigmatism will be a serious handicap in vision.

Ulcus serpens has also a fulminating type, which in a few days may lead to complete necrosis of the cornea. Ulcers caused by *Pyocyaneus* have sausage-like swollen edges, and tend to progress towards the deeper layers of the cornea. Perforation is almost a rule in these cases. There is usually a very vehement iridocyclitis, hypopyon, and a final panophthalmitis. The *Morax-Axenfeld* diplobacillus, which is a saprophyte of the normal conjunctival sac, may cause all types of ulcers from simple catarrhal ones to very severe and typical *ulcus serpens*, which, however, shows a rather slow evolution. Ulcer of mycotic origin (*Actinomyces*, *Aspergillus*, etc.) often produce ring-like and circular forms in the central portion of the cornea.

In case of a ring abscess, the pathological process begins in the parenchyma as a ring-like suppurative infiltration. It is followed by panophthalmitis as a rule. The infective germ is brought into the parenchyma either by a perforating injury or by metastasis¹⁴. All types of bacterium, even *Proteus*, may be found in such abscesses and ulcers, which usually develop 24 or 48 hours after an injury. Total necrosis of the cornea may follow.

A number of herpetic affections lead to corneal erosions, which may be infected secondarily. Herpes simplex may end in ulcerations as well as keratitis disciformis, in which first a round infiltration will be seen in the corneal parenchyma, and the resulting ulcer may be called endogenous. Other endogenous ulcers are seen in tuberculous and in lepers.

The so-called marginal ulcer begins on the periphery of the cornea, and does not extend farther. It has a chronic evolution, and a tendency to recurrences. A number of primary diseases may lead to formation of marginal ulcers. The catarrhal marginal ulcer is usually a part of an acute or chronic conjunctivitis brought on by a variety of germs (*Staphylococcus*, *Streptococcus*, *Pneumococcus*, *Diplobacillus*, *Koch-Weeks bacillus*, etc.). There is first an infiltration at the conjunctivo-limbal region, with edema. This is followed by erosion of the epithelium so that several small flat ulcerations may be seen around the limbus, which sometimes may become confluent. Such ulcers heal spontaneously.

Another variety of the marginal ulcer is

the one caused by the *Zur Nedden Bacillus*. It is a very rare affection, observed only in certain foreign countries. Infarction of the Meibomian glands with calcareous deposits in the lumen of the tarsal glands may be a constant injury to the cornea, with a resulting traumatic marginal ulcer. Trophic disturbances in a senile arc or in rosacea keratitis may also produce marginal ulcers.

A peculiarly sinister type of corneal ulceration is the one called *ulcus rodens* or *Mooren's ulcer* or *keratitis rodens*²⁶. It is a rather rare affection, and only about 160 cases have been described as far. It greatly resembles ulcers developing in rosacea, herpes or in neuroparalytic keratitis. Its cause is not infection, not a dystrophy, nor other local factor. Recently, several authors ascribed it to deficiency of vitamin B or A²⁹, since it heals under locally applied cod liver oil ointments better than by any other measure²⁶. It usually begins as a marginal ulcer, and gradually involves the entire cornea. At its progressive end there is a narrow grayish zone of infiltration which separates the ulcer from the otherwise healthy cornea. The diseased portion of the cornea is vascularized, and there is no hypopyon. Patients, who are mostly middle-aged, suffer much pain. In 50 per cent of the cases the ulcer is bilateral.

The general principles of the treatment of corneal ulcers are very simple: (1) prevent infection in cases of eye injuries, (2) stop the infection and the progress of ulceration, (3) mitigate the sequelae of ulceration.

The prevention of infection includes a proper first-aid treatment of eye injuries. In the Edinburgh mines even the slightest eye injury is treated with the utmost care, and eye drops of a 10 per cent solution of Albucid are used as freely and as routinely as the Crede drops here in America³. Others recommend the routine use of 1 per cent optochin ointment for the prevention of pneumococcic ulcers after eye injuries. Treatment of any existing conjunctivitis is also necessary. If an eye with dacryocystitis is injured, either Toti's operation will be needed, or blocking of the lacrimal sac by Green's method¹¹, which latter is also good for relieving photophobia and pain associated with already existing ulceration.

For the arrestment of infection and the progress of an existing ulceration, all sorts of treatment have been recommended, treatment with specific substances such as sera, vaccines, iontophoresis of optochine, opotherapy with extracts or lysates of lacrimal glands, chemotherapy, caustics, radiotherapy, and surgical interventions. They all may be tried with more or less success, and one should begin with the simpler measures, and use more desperate means when simpler remedies are of little help. As the ulceration

progresses, various symptomatic remedies become indicated such as lavage of the conjunctival sac every 3-4 hours, mydriatics and miotics according to the condition of the iris, etc. Generally, there should be no dressing or bandaging used unless the cornea is very thin, and needs extra support to prevent perforation.

Among the chemotherapeutic substances, recently the sulfonamides proved to be of great value. Sulfanilamide caused rapid recovery in cases of *Mooren's ulcer*². Roggenkaemper, in 1939, stated that *prontosil*, used in the form of subconjunctival injections in one-half cc doses, may cure *ulcus serpens* without any surgical intervention. The scar tissue will be rather thin so that vision will not be greatly handicapped. Sulfapyridine was found valuable by some in pyocyanous and trachomatous ulcerations of the cornea^{3,20}, while others⁴ recorded unfavorable results from this drug in pyocyanous ulcers. Albucid in a 30 per cent solution, or used as a powder locally, has been also praised³. Of course, tincture of iodine is an old proved local remedy for many types of ulcer.

Ultraviolet irradiation has been recommended for every stage of corneal ulceration by Linn, and many others. It should be applied at a distance of 10 mm from the ulcer; the first dose may be an irradiation for 30 seconds, followed by from 20 to 50 seconds irradiations on successive days; three to five treatments may suffice. Others experimented with x-rays, unfiltered x-rays³¹ and *grenz-rays*¹², which all have been claimed effective in the more severe types of ulceration.

Caustics such as phenol, 20 per cent Zinc sulfurate, or 0.3 per cent Zinc sulfurate by iontophoresis have been also found useful in certain cases. Brown recommends the early use of thermocautery. This, together with paracentesis of the cornea, may be very valuable. The paracentesis may be also indicated by the presence of hypopyon; the new aqueous fluid, which will form itself after such an operation, may contain more immune bodies or may stimulate the formation of immune bodies. Some type of fistulization operation is almost universally recommended in order to reduce the dangerous intraocular tension. Preparation of conjunctival flaps may become also necessary in cases of neglected ulcers. In very desperate cases, surgical splitting of the ulcer has been done by a few ophthalmologists. Of course, when the ulcer resulted in permanent damage to the eye, many other surgical interventions may be considered. Sometimes, an extraocular operation may be all that is needed for destroying the focus and source of the corneal infection. Thus, healing of corneal ulcers has been reported after tooth extractions or after tonsillectomies.

Heat in any form may increase the sluggish metabolism of the cornea and, after removal of the infection, may quicken recovery. Even artificial fever, produced by non-specific foreign proteins or by physical means, may find its justification in the treatment of corneal ulcers.

The combination and selection of the methods of treatment must be dependent chiefly on the infective germ and on the type of corneal ulcer. Ulcers caused by the Morax-Axenfeld diplobacillus are easily treated with Zinc sulfate. Mycotic ulcers need cautery and much scraping of the diseased and healthy tissue. Ring abscess is chiefly symptomatically treated, and with the aid of parenteral protein therapy. Herpetic ulcers need scraping, then a touch with tincture of iodine, and dressing: next day, the epithelium is usually regenerated. Ulcers developing in keratitis disciformis yield to iontophoresis with Zinc, or Iodides, to heat and to subconjunctival saline injections. Mooren's ulcer is recently treated with local cod-liver oil ointment²⁶ and with subconjunctival cyanide injections¹⁷. It should be also mentioned that much of the local medication can be brought into permanent contact with the ulcer by means of contact glasses, the use of which has been promoted in ulcer therapy chiefly by German authors.

This paper comprises the views of approximately 32 American and foreign leading ophthalmologists. In conclusion I would like to briefly state what I think are some of the most important points in the treatment of corneal ulcers, which are practically the same as that of Baird and Clay³³.

1. Vitamin therapy plays a greater part in corneal disease than has heretofore been

suspected. I like to give 50 to 100,000 units daily.

2. A solution containing some sulfonamide, atropine and some local anaesthetic should be used regularly unless the patient develops a sensitiveness to its use.

3. I like the use of a pad, when the corneal epithelium is broken.

4. I have obtained my best results since I have been using x-ray in bacterially infected corneal ulcers.

5. I believe that many corneal ulcers are overtreated; more damage has been done with overtreatment than undertreatment. The simplest possible effective treatment without daily insult to the cornea is desirable³³.

DISCUSSION

JAMES R. REED, M.D.

OKLAHOMA CITY, OKLAHOMA

I have enjoyed this excellent paper. For many years Doctor Henley has written abstracts of Eye, Ear, Nose and Throat articles for our State Journal. That stimulates wide and critical reading and in this paper we benefit from that for he brings us views from numerous authorities.

So many views serve to emphasize the seriousness and importance of corneal ulcers and that we are still searching for better treatment.

I agree with Doctor Henley, that we must avoid over-treatment of corneal ulcers. I also agree that vitamin therapy is very important. Vitamins A, B-1, B-2 and C are helpful in corneal healing. Let us not forget our old remedies such as: mercuric chloride ointment, trichloroacetic acid, and foreign protein therapy.

Wartime Tuberculosis Control In Oklahoma*

RICHARD M. BURKE, M.D.*

OKLAHOMA CITY, OKLAHOMA

The war has greatly stepped up the tempo of tuberculosis case-finding activities. The millions that are now being x-rayed, largely as a result of the war effort, is providing us with an opportunity to make the war yield constructive results in tuberculosis control. We believe that it is now well within our power to accelerate the present decline in

mortality rather than merely to keep in check the anticipated wartime rise. In Oklahoma, as elsewhere, thousands of chest x-rays are being taken where only hundreds were taken three years ago. As a result much tuberculosis is being uncovered.

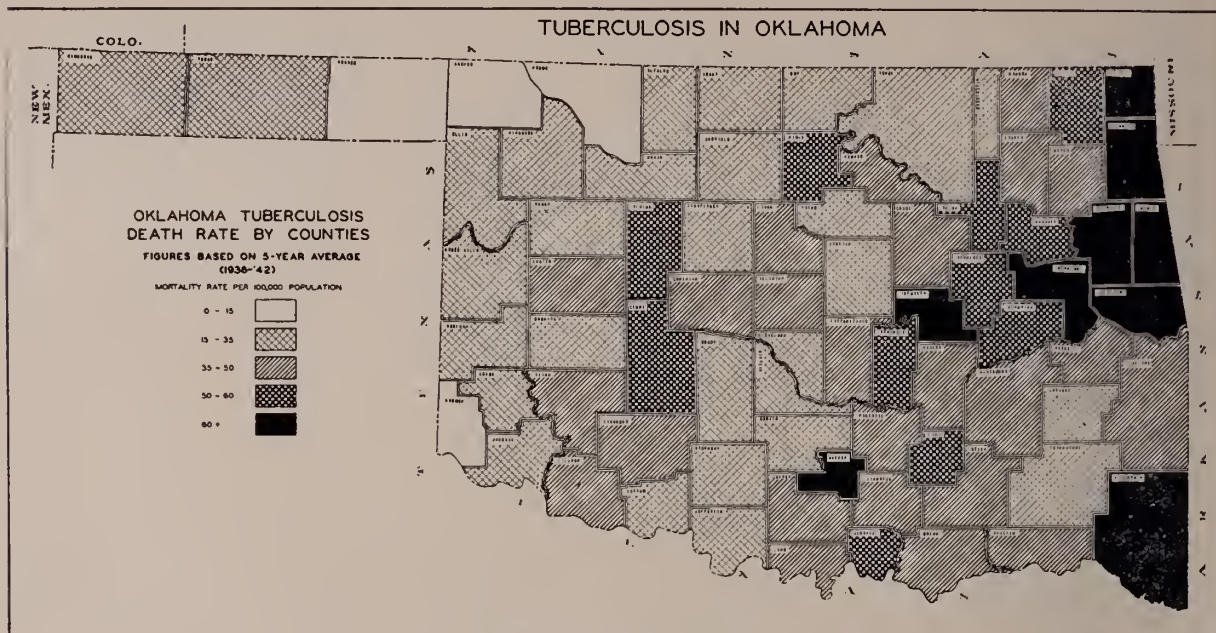
OKLAHOMA'S CASE-FINDING PROGRAM

Unification and direction of the tuberculosis program in the state is provided

*Read before Annual Meeting, Tuesday, April 25, 1944, in Tulsa.

through the State Health Department's Division of Tuberculosis Control. Its program in turn is coordinated with and supplemented by the work of the State Tuberculosis Association. This unofficial agency now has 67 county-wide tuberculosis associations organized. The 1943 state Christmas Seal Sale totaled \$141,423.00.

lers, special racial groups, and low income groups. Tuberculosis is a disease of the poor, being seven times more frequent among the unskilled worker than among the professional man. With this in mind and with our limited case-finding facilities, first choice is given to projects among the low income groups.



MAP No. 1—Tuberculosis in Oklahoma.

The Division of Tuberculosis Control has two objectives: one, to find tuberculosis, two, to properly care for those individuals who have active disease. The machinery for carrying out these two objectives is set up in the 37 counties having full-time Health Departments. Two-thirds of these departments are located in counties with high tuberculosis death rates. Their case-finding program centers around the examination and follow-up by x-ray of contacts (persons exposed to a known case of tuberculosis). Chest clinics are held about once a month with the x-rays being taken and interpreted by State Health Department machines and personnel. Home supervision is carried out by the local nursing staff when an active case remains in the home. Post-sanatorium care is also provided. Pneumothorax refills can be obtained at eighteen points in the state. This service is financed by Christmas Seal money.

Contact case-finding yields 2 per cent clinically significant tuberculosis as contrasted with the 0.3 per cent found among the general population. Besides this method of case finding, each health department conducts survey projects of its own choosing each year. Examples of such projects include the examination of school personnel, food hand-

In counties having no health departments, chest clinics are held about once a year. These clinics are arranged by the State Tuberculosis Association, with the State Health Department taking and interpreting the chest films. Incidentally, all x-ray films used throughout the state are paid for from county Christmas Seal funds. The volume of x-rays taken by the Health Department has been increasing despite personnel difficulties and budget limitations. Fifteen thousand persons were x-rayed at 300 clinics in 1943-44.

TRENDS IN CASE FINDING

The Tuberculin Test

The wider use and availability of the x-ray has changed our policy in regard to the use of the tuberculin test in regularly conducted chest clinics. It is no longer used as a preliminary screening method to determine who is to be x-rayed. All persons admitted to the clinic are x-rayed on their initial visit. However, those exposed to an active case of tuberculosis are tuberculin tested after their contact is broken. If the reaction is then negative, they are no longer followed. If the reaction is positive, they are followed by

periodic x-rays for a variable length of time depending on the age of the patient.

Examining Children

Tuberculosis case-finding efforts have long since shifted from the child to the adult. Grade school surveys have their place as an educational measure, but are an expensive and unprofitable means of discovering tuberculosis. At present, we x-ray all children who are contacts but we do not follow them further until they reach the age of 15 years. We do not school tuberculin testing and x-ray surveying except in senior high schools.

Mass X-ray Surveying

The big trend in case-finding is toward the mass x-raying of all adults. This movement has been given great impetus by the war and the low cost miniature film. The miniature machine can take 300 to 500 films per day for a few cents apiece. Since 1940, 18,000,000 men have been x-rayed in Induction Stations, and another 3,000,000 chest x-rays of industrial workers have been taken. Many counties throughout the United States have bought miniature x-ray machines and are x-raying every person in the county. California's announced goal is to make it possible for everyone in the state to be x-rayed by 1950. In Canada the Province of Saskatchewan is well on its way to achieve such

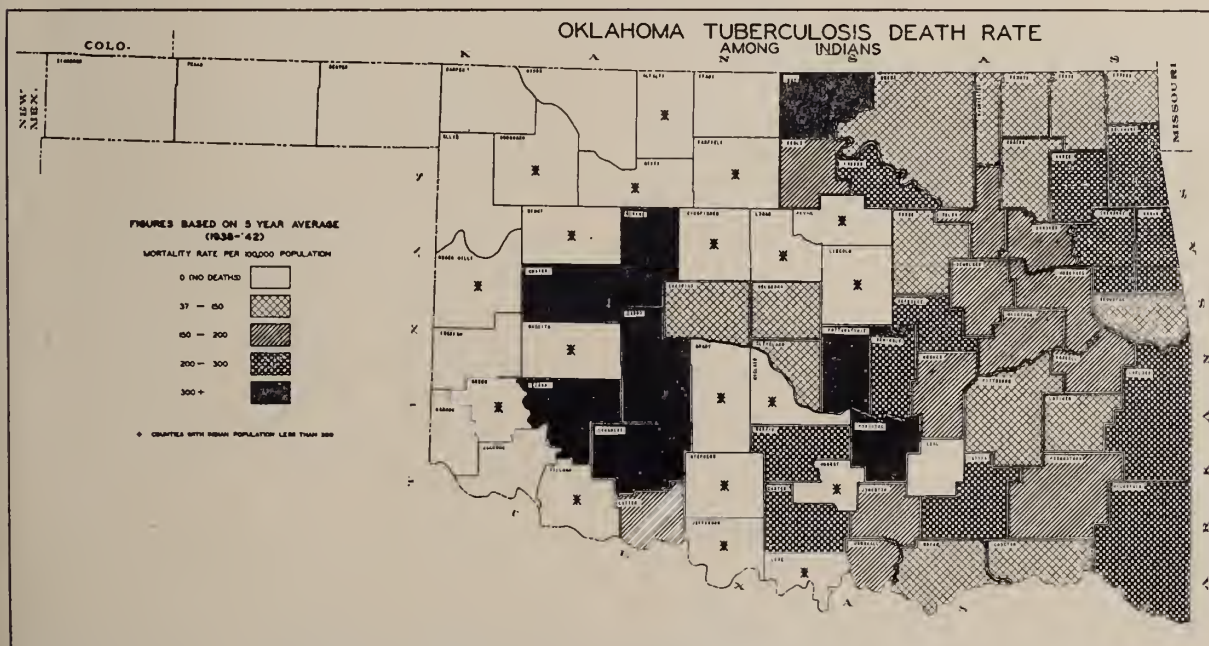
OKLAHOMA PROBLEMS

The Non Whites

The state's chief control problem is among the non-whites. They comprise 9.9 per cent of the population, and in 1943 accounted for 36 per cent of the tuberculosis deaths. We have the largest Indian population of any state (55,951). Their tuberculosis death rate is seven times greater than that of the Whites. An intensive case-finding program is planned by the Indian Service, which is to include the x-raying of all Indians. Adequate sanatorium facilities are available (320 beds). The Health Department works with the Indian Service conducting special clinics for them as well as x-raying many Indians at the regular chest clinics.

Our Negro population of 149,651 has a mortality rate four times greater than that of the Whites. The state provides them with 70 sanatorium beds. A most urgent need is for at least double this number of beds. One-third of the Negro population lives in Oklahoma City, Tulsa, and Muskogee, which areas account for 37 per cent of the Negro deaths.

Oklahoma has a small Mexican population, approximately 7,000. Their death rate is as high as the Indians'.



MAP No. 2—Oklahoma Tuberculosis Death Rate Among Indians.

a goal. Here in Oklahoma the Health Department operates one 35mm. photoroentgen machine. So far, it has been used largely for the examination of inmates of state institutions and for small industrial surveys.

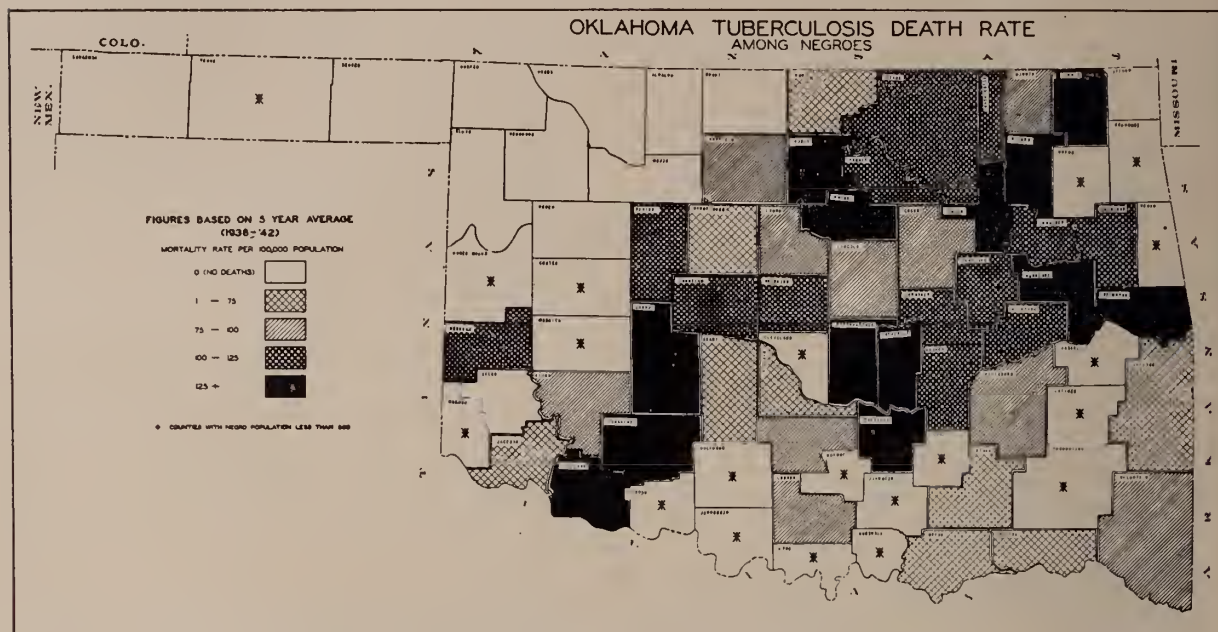
Sanatoria

The state's sanatoria have found it impossible to keep all of their beds open because of shortage of help. For the past two years there has been approximately 200 beds

empty out of a normal capacity of 600. Even at full capacity we are far short of the recommended minimum ratio of two beds for every death. This bed shortage is preventing us from fully capitalizing on the great case-finding gains that are being made. All the

found. Now every inmate is x-rayed on admittance. All cases discovered are properly segregated.

An increasing number of general charity hospitals are routinely taking admission chest films and are discovering 2 per cent



MAP No. 3—Oklahoma Tuberculosis Death Rate Among Negroes.

new cases found cannot be properly segregated and treated.

Age Peaks

The tuberculosis death rate for white males now climbs steadily with age. Their peak death rate 40 years ago was 35 years of age. Today, the peak is not reached until the seventh decade. The peak death rate for females has not shifted, and remains around 25 to 30 years of age. All this means that the man past 50, as well as the young woman, is receiving special attention from the case worker. Getting older people to attend clinics is often a real task, but it is well worth the effort. This shift in mortality suggests that we should consider a change in our present admission regulations to state sanatoria so that older men, possibly up to 60 years of age, can gain admission.

State Institutions

A problem which we are now tackling is tuberculosis in state institutions. The incidence of tuberculosis in Oklahoma is ten times greater in mental hospitals than among the general population. In 1943, 7 per cent of Oklahoma's tuberculosis deaths were traced to the mental hospitals. Recently a miniature x-ray survey was conducted at the State Penitentiary at McAlester. A rate of 3 per cent reinfection tuberculosis was

reinfection tuberculosis.

Legislation

During the past year there has been agitation for legislation making it possible for the health officer to forcibly place the recalcitrant tuberculous patient in a sanatorium. If passed, such a law would seldom need to be invoked, but it would strengthen the hand of the health officer. Other legislation such as compulsory chest x-rays for teachers and food handlers has been discussed. We believe such discriminatory legislation is of questionable value. It tends to form a false sense of security among the public and the individuals so certified as being free from disease. More is to be gained by education and by seeking voluntary cooperation.

Silico-tuberculosis

In the lead and zinc mining district of Northeastern Oklahoma, we have an edemic area of tuberculosis with a mortality rate of 158.5 per 100,000. The re-establishment of a full-time health department in Ottawa County should aid in combating this situation.

Education

The greatest boon to health education, as far as tuberculosis is concerned, has been the chest x-ray. One out of every five adults in the United States has been x-rayed since

Pearl Harbor. This does not automatically educate all these people, but it does start them thinking and asking questions. Health education is directly approached through the schools and teachers. This summer short health education courses for teachers will be given by Health Department personnel at four state colleges. The subject of tuberculosis will be given full attention.

WAR AND TUBERCULOSIS

The war has brought a marked rise in tuberculosis mortality throughout most of this strife-ridden world. England's rate in the first two years of the war jumped 12 per cent. This year Parliament, alarmed at the rise, appropriated 30,000,000 Pounds for miniature x-ray surveys and pensions for the tuberculous. In France there has been a marked increase in tuberculosis, particularly among children. Military tuberculosis is common. In the United States the death rate has continued to decline but at a slower pace. In some crowded defense plant areas there has been a slight rise, but elsewhere the trend is still downward. Oklahoma's declining rate is shown in Tables No. I, and No. II.

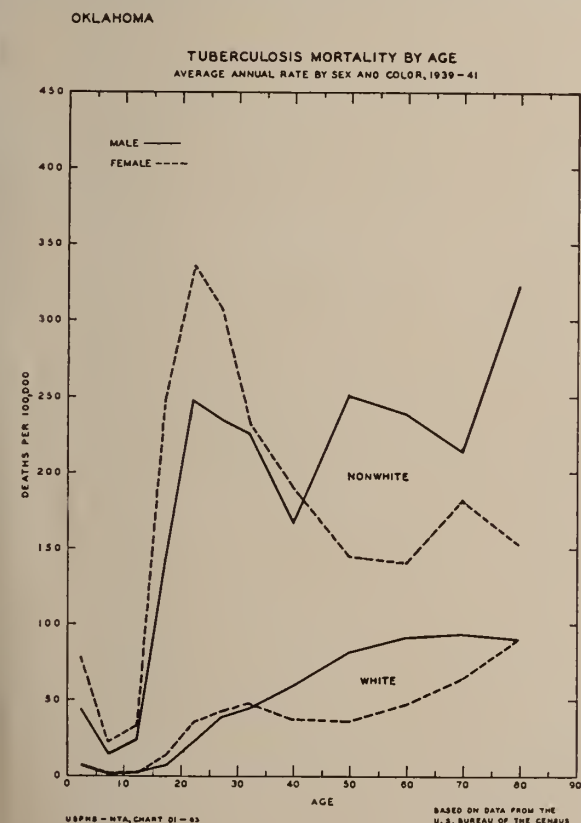


FIG. No. 1—Tuberculosis Mortality by Age for Oklahoma.

Oklahoma has had some dislocation of its rural population with many going outside the state to war jobs and a lesser number moving about within the state to the cities. In the shuffle the state has lost 306,000 peo-

ple, or 13 per cent of the population since 1940.

In the Oklahoma City metropolitan area there has been an increase of 58,000. Housing conditions, at first inadequate, now are satisfactory. The majority of these people are working in the Douglas Plant and at Tinker Field, both of which routinely x-ray all employees. The reporting and subsequent follow-up of cases found has been good. Sanatorium care, when required, has been provided in most instances within three weeks or less. Tulsa has gained some 42,000 in

TABLE NO. I

Tuberculosis Mortality Rate
(Per 100,000)

Year	Okla.	U. S.
1940	48.2	45.9
1941	46.2	44.4
1942	45.2	43.1
1943	44.9	41.9

population and has been able to absorb this influx without any serious over-crowding. The pre-placement x-ray here has not been used quite so widely as in the Oklahoma City area. There are fewer sanatorium beds available for this section of the state and as a result admissions have been slower. Their problems have been greater yet they had 47 fewer tuberculosis deaths in 1943 than in 1940.

It is believed that 100,000 Oklahoma workers have been given pre-placement x-rays during the past two years. This has uncovered an estimated 250 cases of tuberculosis. The follow up and examination of contacts of these persons has been done where the patient lives in a county with a full-time Health Department. In the remaining counties follow-up work has been haphazard.

Selective Service is now by far our greatest ally in fighting tuberculosis. All persons entering the Armed Forces are x-rayed and will be x-rayed again on discharge. Thus far some 30,000 cases are estimated to have been discovered by this routine. In Okla-

Table No. II

No. of Tuberculosis Deaths
in Oklahoma

Year	White	Negro	Indian	Mex.	Total
1940	754	206	152	5	1117
1941	623	226	178	6	1033
1942	623	197	144	9	973
1943	610	185	128	6	929

homa 700 cases have been found, 65 per cent of which are previously unrecognized.

An analysis was made of 1577 Selective Service registrants rejected or deferred because of pulmonary pathology. The figures are given in Table No. III. It is to be noted that there were 240 active cases discovered:

24 per cent minimal; 45 per cent moderately advanced; and 31 per cent far advanced.

It is felt that most of the cases listed under pulmonary calcifications represent healed primary infection. Many, however, probably represent a healed reinfection tuberculosis of minimal extent and often not typical in appearance.

Table No. III

Analysis of 1577 Selective Service Registrant Rejected or Deferred Because of Pulmonary Pathology

Clinically Significant Pulmonary

Tuberculosis	456
Pulmonary Calcifications	911
Non-tuberculosis Pulmonary Conditions	210
Total	1577

Classification of Reinfection Tuberculosis Found

Stage of Disease	Active No.	Active %	Inactive No.	Inactive %	Total No.	Total %
Minimal	59	24	180	83	239	50
Mod. Adv.	106	45	33	15	139	30
Far Adv.	75	31	3	2	78	20
Totals	240		216		456	

We review all films taken of registrants rejected because of lung pathology by Oklahoma's Induction Stations. Notifications are then sent to county health departments of those showing definite evidence of reinfection tuberculosis. No notifications are sent on those showing excessive calcifications or a few stable fibro-calcified areas.

Films of these same rejectees are also reviewed for the Advisory Medical Board for Lung Pathology. The x-rays of those that might be reconsidered for military service are brought before this Board and as a result many men have been reclassified. In general, those that have had a reinfection tuberculosis are not reconsidered regardless of the present appearance of the lesion. There is no way to assure oneself of the stability of these lesions without protracted observation. These individuals, however, should not be excluded from industry if the lesion can be classified as arrested. Those with pulmonary calcifications, offer a different problem. The Army regulations which stipulate that rejection or non-rejection of registrants because of the size and number of calcifications is a compromise between two schools of thought on the subject. One group believes registrants should be accepted regardless of the size or number of calcifications while the other group believes calcifications to be precursors of the reinfection type of tuberculosis. The Board in their recommendations has been inclined to adhere to Service regu-

lations for those under 25 years of age, but above this age those with excessive calcifications are frequently recommended for reclassification.

During the first World War tuberculosis ranked first as a cause for medical discharge from the Service. In this war it ranks tenth. More than 200,000 veterans of the first World War have been admitted for treatment to hospitals and sanatoria operated by the Veterans Administration during the past 25 years. Records from the office of the Surgeon General, War Department, indicate that hospital admission rates for tuberculosis in the United States is running about one-fourth of what they did in the first World War. With the present strength of the Armed Forces approximately three times that of the first World War forces, it would suggest that tuberculosis will still be a major problem.

It is estimated that approximately 10,000 cases of tuberculosis were taken into the Army. The majority of these are detected before being dispatched to combat areas. Very few men are being sent back because of tuberculosis. The total figure for November and December, 1943 was only 157.

The Veterans Administration have adequate facilities at present for the tuberculous. Here in Oklahoma we also have a State Veterans Hospital which accepts tuberculous patients.

SUMMARY

Tuberculosis case-finding activities have tremendously increased since the onset of the war. Selective Service has uncovered 600 cases of tuberculosis in Oklahoma since July, 1941. Industry's pre-placement x-raying program has brought to light another 250. Along with this the private physician, the regular case-finding activities of the State Health Department, the State Tuberculosis Association, and the Indian Service have been finding about 800 cases yearly. All this provides a great opportunity to accelerate the downward trend of the tuberculosis rate instead of merely hoping to check the anticipated wartime rise. Shortage of sanatorium beds is preventing us from taking full advantage of this situation. Expansion of the State's Tuberculosis Control Program is needed now.

All old time country doctors will appreciate this. "Washington, Iowa, February 13, 1867. In riding in an open sleigh, from Oshkosh to Ripon, in a fiercely cold snowstorm driving in my face, I blessed the speed and power of the horses. Their endurance makes them inestimable in this rough country."—Perry, Bliss. *The Heart of Emerson's Journals*, page 319. Boston and New York.

Surgery Of the Spleen*

OSCAR WHITE, M.D.

OKLAHOMA CITY, OKLAHOMA

The study of surgery of the spleen is one of intriguing interest because it is involved in many abnormal conditions and because of the lack of positive knowledge of the normal physiology of the spleen and its role in disease. Some of the known functions of the spleen are: to act as a reservoir for blood; to form lymphocytes and monocytes, phagocytosis of bacteria, inert particles, white blood cells, and probably platelets; destruction of red blood cells, formation of bilirubin and the storing of iron.

The removal of the spleen causes no demonstrable permanent effects. Splenectomy in the normal mammal results in a mild temporary anemia, increase in reticulocytes, increased resistance of red blood cells to hypotonic saline solution, cellular hyperplasia of the bone marrow and a marked rise in the platelet count.

These changes are transitory as other organs of the body apparently assume the functions of the spleen. There is no evidence to prove that splenectomy renders man less resistant to infection.

Surgically, splenic lesions and conditions or diseases involving the spleen may be divided into three groups, as follows:

A. Conditions for which splenectomy is of definite value

1. Traumatic lesions and non-traumatic rupture.
2. Anomalies of position and mechanical accidents (torsion and a movable spleen).
3. Spherocytic, hemolytic jaundice.
4. Thrombocytopenic purpura.
5. Splenic anemias (Banti's syndrome).
6. Abscess (certain cases).
7. Cysts and hemangiomas.
8. Neoplasms.
9. Aneurysm of the splenic artery.
10. Primary splenic neutropenia.
11. Any condition in which a large spleen causes mechanical distress, if splenectomy is not contraindicated.

B. Conditions for which splenectomy is of possible value.

1. Gaucher's disease.
2. Erythroblastic anemia.
3. Sickle cell anemia.
4. Cirrhosis of the liver.

5. Tuberculosis of the spleen.

C. Conditions for which splenectomy is of little or no value.

1. Syphilis.
2. Amyloidosis.
3. Kala-azar.
4. Malaria.
5. Schistosomiasis.
6. Polycythemia vera.
7. Leukemia.
8. Hodgkin's disease.
9. Hemochromatosis.
10. Anomalies.
11. Other diseases.

DIAGNOSIS OF CONDITIONS IN WHICH SPLENECTOMY IS OF DEFINITE VALUE

The spleen is an integral and important part of the hemopoietic system and, as such, is involved in all of the so-called diseases of the blood. It is, therefore, necessary to make a thorough and complete study of the blood in all cases of splenomegaly. This should include a complete count, differential count in a stained smear, hemoglobin estimation, morphological study of the cells, platelet count, coagulation, and bleeding time, estimation of fragility of the red cells, icterus index, number of reticulated cells present, and Wassermann reaction.

In some of the lesions to be considered, it is also necessary to make a thorough study of the bone marrow which is usually obtained by sternal puncture.

A complete discussion of the diagnosis of the surgical lesions or diseases involving the spleen would be impossible in the time allotted, but I would like to review very briefly a few of the more important symptoms and findings in three or four of the conditions which are encountered at comparatively frequent intervals, and in one condition which is apparently quite rare and which is cured by splenectomy.

Splenic anemia or Banti's syndrome (congestive splenomegaly) is characterized by signs and symptoms which vary with the disease. An enlarged spleen may be the first sign. Anemia may be present for years. Occasionally, hematemesis may be the first indication of illness. Hemorrhage from the mucous membranes and into the skin occur later and usually signify a well established cirrhosis of the liver. Still later, ascites, loss of weight and jaundice occur. The labora-

*Delivered before the Section on Surgery at Annual State Meeting, April, 1944, at Tulsa.

tory findings depend on the stage of the disease. In the early stage a moderate normocytic anemia is present. Hemorrhage results in a microcytic, hypochromic leukopenia and thrombocytopenia are usually present. The coagulation and bleeding time may be normal, the tourniquet test positive, and the icterus index increased. The urine contains urobilin and at times small quantities of bilirubin.

Spherocytic, hemolytic jaundice is characterized by splenomegaly, acholuric jaundice, anemia, a decreased resistance of red blood cells to hypotonic saline solution, (increased fragility) reticulocytosis, and a preponderance of microcytes which are spheroidal instead of biconcave in shape. An infection may be followed by an acute attack manifested by upper abdominal pain, nausea, vomiting, fever, and increased anemia, and jaundice. Other laboratory findings are bilirubinemia, urobilin in the urine, and increased urobilin in the stool. There is an absence of pruritis. Sixty per cent of patients with this disease have pigmented gallstones. Splenectomy nearly always results in a spectacular cure of spherocytic hemolytic jaundice.

Thrombocytopenic purpura is characterized by hemorrhage in the skin and subcutaneous tissues and from the mucous membranes of the nose, gums, gastro-intestinal tract, and endometrium. There is a marked reduction of the platelets. The condition may be acute, subacute, chronic or remittent. The disease usually occurs before the age of thirty, rarely in older individuals. In children it tends to be self-limited and spontaneous recovery is frequent. It is five or six times as common in the female as in the male.

Thrombocytopenia is usually marked. The coagulation time is normal, clot retraction is absent or very prolonged and the clot is fragile, the bleeding time is prolonged, and the tourniquet test is positive. Anemia due to blood loss may be present. Leukocytosis, with an increased neutrophil count is usually found. The spleen is rarely palpable. Splenectomy is definitely indicated and usually cures the disease. It is amazing to observe the sudden dramatic cessation of bleeding from the abdominal wall as soon as the splenic pedicle is clamped.

PRIMARY SPLENIC NEUTROPENIA

The last condition to be discussed at this time is a syndrome reported by Wiseman and Doan as recently as 1939. It is closely related to congenital hemolytic icterus and essential thrombocytopenic purpura.

The pioneer work of Barcroft, McNee, Lord Dawson, and Krumbhaar which established sound concepts of the functions of the spleen has been verified and supplemented by thorough controlled studies of the diseases of

the spleen in the human. These concepts have been established by means of improved techniques by such clinical hematologists as Kaznelson, Frank, Dameshek, Doan, Wiseman, and others. These studies have led to improvement in the management of known splenic syndromes and also to the recognition of hitherto unsuspected disease entities involving the spleen. The essential phagocytic activity of the cells of the reticuloendothelial system for red and white blood cells, platelets, bacteria, and other foreign matter has long been known and recognized. This activity is known to be a normal physiologic process. Any increase in this physiologic phagocytosis of other cells may produce a pathologic disturbance of equilibrium which may be characterized by a marked diminution in one or more of the circulating elements of the blood. For example, excessive erythrocyte destruction occurs in congenital hemolytic icterus and abnormal platelet destruction in essential thrombocytopenic purpura. As a result of these well known and accepted facts, it was felt that a similar excessive activity of the splenic macrophages for granulocytes could occur, and in May, 1939, Wiseman and Doan reported five cases of a syndrome which they have designated as Primary Splenic Neutropenia. This syndrome has since been recognized, confirmed, and reported by several other clinics.

An analysis of Wiseman and Doan's cases shows that the findings which were common to all five cases were profound neutropenia, panhyperplasia of the bone marrow, splenomegaly, and a return to normal following splenectomy. Hemolytic anemia and thrombocytopenic purpura of varying degrees and combinations were found to be present. In all cases the anemia was hemolytic in type with reticulocytosis, and jaundice with negative direct van den Bergh reaction.

From the knowledge obtained by a complete pre and postoperative study of these cases, there seems little doubt that a single mechanism is responsible for the varying degrees of anemia, neutropenia or thrombocytopenia since it has been shown that all three are markedly improved within eight hours following splenectomy. It has also been shown through direct supravital studies that there is a marked increase in number and phagocytic activity of the macrophages, each one of which is shown to be actively destroying not only neutrophilic leukocytes, but also red blood cells including normoblasts to a lesser degree. It is quite natural to conclude that this syndrome is a direct result of hypersplenism and is closely related to congenital hemolytic icterus and essential thrombocytopenic purpura and possessing a comparable mechanism. In the former disease, the activation of the clasmatoocytes of the spleen

is directed chiefly toward the red blood cells and in the latter chiefly toward the thrombocytes and in primary splenic neutropenia, chiefly toward the neutrophilic leukocytes.

The association of splenomegaly and leukopenia with a wide variety of chronic infections is too well known to require extended comment; however, the combination of thrombocytopenia, severe neutropenia with myeloid hyperplasia in the bone marrow and hemolytic anemia are not the classical features of chronic infections.

Malignant neutropenia, drug induced or otherwise, is easily differentiated by the history, clinically by the absence of an enlarged spleen and hematologically, by the bone marrow which is hypoplastic for myeloid elements with marked maturation arrest.

Leukemia of sub-leukemic myeloid type may present the most difficult differential diagnosis. Careful bone marrow studies, and thorough blood examinations are very important in that splenic neutropenia never shows the qualitative alterations in the myeloid elements which characterize the myeloid leukemias.

The diagnosis of primary splenic neutropenia is based on the clinical and hematological findings which, in a typical case, are as follows:

1. Clinical.
 - a. Splenomegaly.
 - b. Occasionally purpura (depends on degree of thrombocytopenia).
 - c. Occasionally oral ulceration (depends on acuteness and severity of neutropenia).
 - d. Occasionally mild icterus (depends on degree of associated anemia).
2. Hematology.
 - a. Bone marrow.
 - (1) Hyperplastic for myeloid series and, if hemolytic anemia is pronounced, erythroid series.
 - (2) No abnormal cells present.
 - (3) Not leukemic.
 - b. Blood.
 - (1) Marked specific neutropenia.
 - (2) Anemia, when present, is macrocytic, hyperchromic in type.
 - (3) Reticulocytosis if anemia is definite.
 - (4) Increased indirect van den Bergh depending on grade of anemia.
 - (5) Thrombocytopenia variable.

Clinically, the presence of an easily palpable non-tender spleen is the most important diagnostic factor. If, with this finding, there is a severe neutropenic leukopenia, with a variable even though slight anemia, with thrombocytopenia, and the bone marrow

shows a panhyperplasia including the myeloid elements without maturation arrest or pathological alterations, the diagnosis is positive enough to justify splenectomy.

SUMMARY OF SPLENECTOMIES AT UNIVERSITY HOSPITAL, OKLAHOMA CITY FROM 1932 TO 1942 INCLUSIVE

During this period of 11 years there were 22 splenectomies with a mortality of 31 per cent. The lesions and the results following splenectomy were as follows:

1. Banti's Syndrome: 8 cases with 4 deaths.
2. Thrombocytopenic Purpura: 4 cases with no deaths.
3. Chronic Malaria: 2 cases with no deaths.
4. Traumatic Rupture: 1 case with death.
5. Hypoplastic Anemia: 1 case with death.
6. Gaucher's Disease: 1 case with excellent result.
7. Spherocytic Hemolytic Jaundice: 4 cases with 1 death 48 hours post-operative.
8. Primary Splenic Neutropenia: 1 case with cure.

It seems remarkable that only one splenectomy was done on an average of every six months in this comparatively large teaching hospital of 425 beds. It seems still more remarkable that during this 11 year period there was only one splenectomy for ruptured spleen.

SUMMARY

The principle reasons for presenting this paper are as follows:

1. To review briefly the physiology of the spleen in health and in disease.
2. To review very briefly the diagnosis of a few well known conditions in which splenectomy is either curative or of definite benefit.
3. To discuss a comparatively newly recognized syndrome which has been designated as primary splenic neutropenia and which is cured by splenectomy.
4. To report the only case of primary splenic neutropenia at the Oklahoma University Hospital which was diagnosed as such by Dr. Wann Langston and which was cured by splenectomy.
5. To report on all splenectomies done at the University Hospital from 1932 to 1942 inclusive.

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THE PRESIDENT'S PAGE

The letter this month is for the purpose of bringing to your attention two very important matters.

I am sure all of you are wondering whether or not there will be a State Meeting this year. We have made application to the Office of Defense Transportation in Washington for permission to hold the meeting, but to date we have heard nothing from them. Inasmuch as all national meetings, and at least seven or eight state meetings, have been canceled, our prospects are none too bright. However, as soon as we have definite information concerning our application we shall so advise the membership by special bulletin.

We are pleased to tell you that the Scientific Work Committee is hard at work on the program and report considerable progress. Several distinguished physicians have accepted invitations to participate as guest speakers. Several others have been contacted, but to date they have not accepted. No serious difficulty is being encountered in procuring a full quota of outstanding and nationally known doctors to be guest speakers. This promises to be a most instructive and enlightening program, providing of course, that we are permitted to hold the meeting. Inasmuch as this may be the only meeting held, an unusually large attendance is expected. Make your plans NOW to attend if it is held.

In the second part of this letter we call your attention to the fact that now is the time of year to renew your membership in your Association by paying your annual dues.

It has been estimated that there are about three hundred practicing physicians in this state who are not members of the State Association. It is our duty to point out to them the advantages of membership and at the same time find out why they have not availed themselves of this privilege. This office would like to see the officers of each County Society give time and thought to this problem and endeavor to get every doctor who is properly qualified to become a member of the State Association.

Every physician owes it to himself and to his patients to keep abreast of the rapid changes taking place in medical economics and in the science of medicine. This we feel can best be done by affiliation with your County and State Association.

Very Sincerely,



President.

P. S. Since the above was written we received a wire that the permit to have the annual meeting has been denied. The Council, in session Feb. 11, decided to permit the members of the Houses of Delegates to select from their number those to attend the meeting of the House. A special bulletin containing more information will reach you shortly.

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Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space. Bibliography listing should follow this order: Name of author, title of article, name of periodical with volume, page and date of publication.

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EDITORIALS

SECRETARIES CONFERENCE

On Sunday, January 21, the Secretaries Conference of the Oklahoma State Medical Association met at the Skirvin Hotel in Oklahoma City for an all day meeting. The session was devoted primarily to the proposed Legislative Program of the State Medical Association.

In the evening a great dinner meeting was held in the presence of a representative group of legislators. The interests and needs of the Medical School were discussed by the genial Dean, Dr. Tom Lowry. Dr. Lowry's program was well presented and his description of the needed facilities at the Medical School was well received. Many questions and expressions of approval came from the audience.

The merits of the Board of Health Bill and the Coroner's Bill were then presented by the President, President-Elect and Dr. Floyd Keller. These also met with a gratifying response and the presentations were followed by an informal discussion bringing out pertinent questions and answers.

On the whole, this meeting of the County Secretaries was a very informative one and promises to bear valuable fruit. Here we

have another example of unselfish devotion to a worthy cause.

At midnight the doctors from all sections of the State who traveled far to attend the meeting, were on the way home where, for at least some of them, urgent calls were awaiting their arrival. We take off our hats to men who make such sacrifices for the sake of humanity.

OUR LIFE LINE

Literally our Navy is our Life Line. Somewhere along this Life Line our boys are suffering and dying without medical care. This is not in keeping with the best traditions of the medical profession. Doctors at home or at War have always been ready to go where duty called regardless of danger. According to the estimate of Naval authorities, 3,000 doctors are needed now. Oklahoma's quota has been placed at 40.

All available doctors should seriously contemplate this need and in the light of the past, the present and the future, decisions should be made. The opinions of patients, neighbors and colleagues are inadequate and impotent as conscience weighs the evidence.

Patients, neighbors and colleagues will forget—conscience never.

If communities without doctors seem forsaken, what about ships and islands, exposed to the exigencies of War as well as disease—without doctors. It is *our* Navy, made up of *our* men, fighting *our* War. It is *our* duty to check their blood, bind their wounds, ease their pains and save their lives. Shall we meet the call? Not only must we face those who come home but ultimately those who perish for want of medical care.

"As ye would that men should do unto you, do ye also unto them."

Dr. W. W. Rucks, Oklahoma City, will be glad to supply all needed information to those who are interested.

WHEN THE INDIVIDUAL BECOMES A CIPHER

In this day of unrest and susceptibility to bureaucratic and socialistic trends, a reading of these paragraphs from Karl Sudhoff¹ will please those who know how Germany has ignored her medical prophets from Schiller to Sudhoff, and who have the prescience to anticipate America's plight when medicine goes the way of many other free enterprises.

"We might perhaps speak during the Babylonian-Egyptian period of a 'communal knowledge' produced by the common labor of the members of a caste that guarded such knowledge as their secret. But this impersonal effort of many individuals of the priestly caste along the shores of the Euphrates was blighted by early paralysis and gradual ossification. Not a single one of the medical personalities that we know from both civilizations contributed in any way creatively to the traditional knowledge nor can any one be considered the discoverer of any important fact or of any valuable curative measure. The individual is a cipher, only the guild, the caste, the corporation is of importance. These are the guardians of the traditional lore, which is codified, becomes obsolete, decays after early stagnation, the principal cause being the lack of leading individuals.

"There is a marked change in the second period, in a modest degree in India, but more significantly among the Greeks, a people so highly endowed by nature. Thinkers and scientists of dominating influence emerge who bring about great and lasting progress in the whole range of the physical and biological medical sciences, a progress that makes itself felt for centuries to come. Each work is backed by its author. These leading intellects for the first time produce a real science, they elaborate and guide it as living individuals. The final conveying of this knowledge to the work of Islam is effected by the intermediation of individuals, through

Greeks, Syrians, Jews, Persians. In the Orient this science, emanating from individuals is never interrupted until the heirs of Dschingis-Kjan hurl their fire brands into the palaces of Bagdad. When in the Occident, Greek Science perished upon the destruction of the Roman Empire, the continuity of tradition was interrupted for lack of competent individuals. If it had been possible to have progress coming from the masses how it would appear among these peoples, full of youthful life, eager to learn, highly gifted! Medicine like all other sciences fell back into the lower impersonal stage. After the lapse of centuries, the labor of the medical guild of Salerno presents itself as the supreme effort of this period of stagnation. A modest guild knowledge there brings about a continuation of ancient medical practice and science on a small scale. Only when the medical individualities of increasing independence of thought and action arise and write their 'works' through the intellectual infection from the Orient, through Constantine the African, the instrument of Providence, is the stagnant mass aroused to life. This scientific life spreads in the young universities of Italy, France, and England; everywhere we find names that make a strong appeal; with the Renaissance the full independence of research is inspired with a new life.

"The time of great scientific personalities, as in the epochs of ancient Greece, has returned; the leaders of progress of most individual type are at work. The long time of 'master minds' runs without interruption from the thirteenth to the twentieth century, many of whom Hemmeter has treated in his book in such attractive and masterful fashion.

"True the 'great man' is the offspring of his people, which has transferred to him the function and responsibility for progress. The people are the maternal womb from which he sprang; he is their creation, for their own higher purposes and for the world at large as well. He is a child of his times. But in spite of all the influence of environment, the great thoughts are his, his very own, the product of that unique individuality that places him among the elect. The people create or produce him by a process not yet understood, for their own purposes and for humanity. Let there be no confusion of ideas about this; let there be clear thinking. It is not the masses who overcome the errors, who tear down the crumbling outward structure, and putting something else in its place, thereby erect the new pantheon of science. To mention only one example of progress, it is not the masses, but a Semmelweis, a Pasteur, a Lister, a Koch, who have bestowed on humanity the

blessings of antiseptics and sepsis. They had the great intuitions, they created the methods and the masses generally accepted them. To great individuals is given the great vision. They wield the bow and what is obsolete falls; according to their own plans they build the temple of the new science. Howsoever many enthusiastic followers may cooperate with them, the work is theirs. That is the lesson which the History of Medicine conveys to the open-minded scientist, from the beginning to the present day.¹¹

1. Sudhoff, Karl: Professor of the History of Medicine, University of Leipzig: *Master Minds in Medicine*. John C. Hemmeter, Introduction, pp xxvi-xxvii. New York Medical Life Press, 1927.

SULFONAMIDE PROPHYLAXIS

Recently several leading medical journals have published articles on the prophylactic use of the sulfonamides especially in the bacterial infections of the respiratory tract, sulfadiazone being the preparation most generally employed.

The reported investigations have been carried on chiefly in the armed forces where the congregation of large numbers of young people, under altered and often unnatural living conditions, created an environment ideal for the transmission of such infections and equally well adapted for the experimental studies which have been reported. While there seems to be a reasonable promise of favorable results, it is too early to accurately

determine efficacy and safety. Even when these questions are definitely settled for well controlled military groups with their special environmental hazards and susceptibilities, the answers may not be applicable to lay groups.

To be considered are: the possible dangers of sustained administration of the sulfonamides even in small doses; the development of sensitivity to the drug; the possibility of producing drug-resistant strains of bacteria.

Even though the prophylactic administration of these preparations to military groups may be justified for the solution of immediate problems, conservative civilian physicians may well await the ultimate effects of such investigations, and the liberal sulfonamide enthusiasts should curb their experimental propensities in behalf of civilian populations.

EXPERIENCE, THE TRUE GUIDE

Physicians have learned the practice of medicine in the school of suffering; in the sick room not in the Senate Chamber. To all discerning minds the most vital values in medicine arise from the crucible of pain like a poem ending with faith, hope and charity. Whatever may be done to medicine, let us hope the personal liberty so vital in the exercise of these three functions may never be lost.

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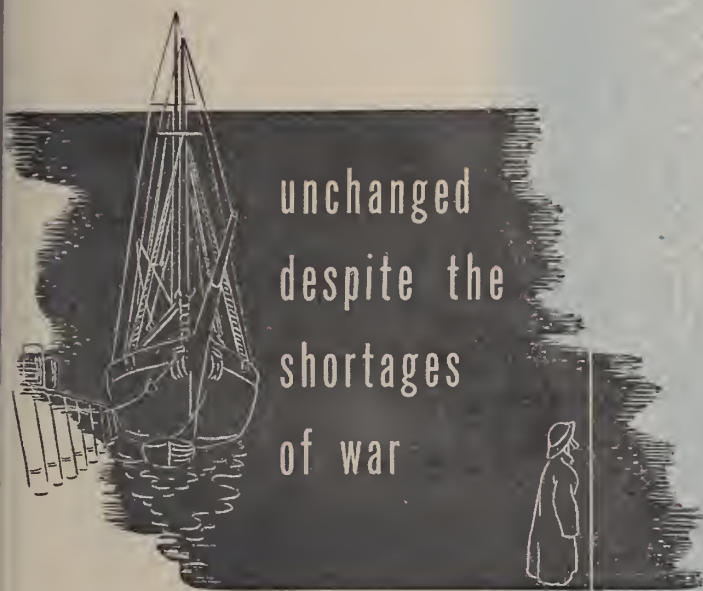
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ASSOCIATION ACTIVITIES

AMERICAN MEDICAL ASSOCIATION PHILADELPHIA SESSION CANCELED

The Board of Trustees of the American Medical Association, after consideration of all factors involved, has officially announced the cancellation of the Ninety-Fifth Annual Session of the Association scheduled for Philadelphia June 18-22. This is the fourth time in the Association's history and the second time during the present war that an annual session has not been held. In 1861 the annual session was postponed for a year because of the outbreak of the war between the states. In 1862 it was again postponed for a year. The 1943 annual session scheduled to have been held in San Francisco was cancelled. Last year the session was held in Chicago. It is expected that a meeting of the House of Delegates will probably be held in 1945 in Chicago at a time to be announced later in The Journal. The action this year is taken voluntarily in order to cooperate to the fullest possible extent with the request of the Office of Defense Transportation and in the interest of the nation's war effort.

LEGISLATIVE PROGRAM DISCUSSED AT ANNUAL SECRETARIES CONFERENCE

On January 21, 1945, the Annual Secretaries Conference was held in Oklahoma City at the Skirvin Hotel. The afternoon meeting was called to order by Dr. C. R. Ronntree, President of the Association and Dr. J. B. Hollis, Mangum, Chairman of the Conference, presided at the meeting. Minutes of the last session were read by the Secretary, Dr. D. Evelyn Miller.

Officers elected for the coming year were: Ben H. Nicholson, M.D., Oklahoma City, Chairman; W. K. Haynie, M.D., Durant, Vice-Chairman; O. M. Woodson, M.D., Norman, Secretary.

Dr. V. C. Tisdal, President-Elect of the Association and Chairman of the Public Policy Committee discussed the Legislative Program and called upon Dr. O. W. Starr of Drumright, Representative for comments on House Bill No. 77. Following Dr. Starr, Dr. Lonis Ritzhaupt, Guthrie, Senator, further discussed the Board of Health Bill.

Dr. Floyd Keller, Oklahoma City, explained the merits of the Medical Examiners System. Mr. Paul H. Fesler, Executive Secretary of the Association, then gave a talk touching on all phases of the Legislative Program and urged the Conference to impress the importance of the Program on the members of their respective County Societies. Mr. Fesler also gave further details concerning the Association's activities and the advertising program of the Journal.

Dr. Lewis J. Moorman, Editor of the Journal, discussed the functions and services of the Editorial Board of the Journal. The Postgraduate Committee was represented by Dr. Gregory Stanbro, Oklahoma City, who outlined various plans for the Committee work.

Dr. James Stevenson, Tulsa, discussed the Prepaid Medical and Surgical Program.

The evening dinner meeting was an informal discussion meeting at which the Senators and Representatives of many counties were entertained. There was animated discussion of the Legislative Program. Dr. Tom Lowry, Dean of the Medical School presented the Program of the Medical School Appropriation. After his explanation, many questions were asked and a general discussion took place.

INTERESTING INAUGURAL EVENT HELD BY OKLAHOMA COUNTY MEDICAL SOCIETY

On January 23 the Oklahoma County Medical Society honored Dr. William E. Eastland, retiring President and new officers of the organization at an annual inaugural dinner-dance at Oklahoma City Golf and Country Club. Arrangements for the event were made by Dr. Walker Morledge and Mrs. Muriel Waller, Executive Secretary of the Society.

The principal speaker, Dr. M. L. Wardell, professor of history at the University of Oklahoma, spoke on "The United States and Her Future in World Affairs."

New officers are Dr. Gregory E. Stanbro, President; Dr. W. Floyd Keller, President-Elect; Dr. Charles M. O'Leary, Vice-President; Dr. Ben H. Nicholson, Secretary-Treasurer; Dr. Wann Langston, Board of Censors replacing Dr. Carroll Ponder. Dr. John H. Lamb, Dr. Nicholson and Dr. O'Leary were elected to the board to replace Dr. C. R. Ronntree, Dr. Eastland and Dr. Morledge.

PUBLICATION OF GARFIELD COUNTY MEDICAL BULLETIN TO BE RESUMED

At a meeting of the Garfield County Medical Society, in December, it was voted to resume publication of the monthly journal, called the Bulletin, publication of which was suspended when Dr. Roscoe C. Baker entered the Armed Forces. He will resume publication of the Bulletin sometime in February.

EXECUTIVE OFFICE OF TULSA COUNTY MEDICAL SOCIETY ENLARGED

The Executive Offices of the Tulsa County Medical Society at 1202 Medical Arts Building, Tulsa, have been remodeled following the addition of a large room to the Society quarters. The Medical Library has been expanded, allowing much needed space for books and journals and for a reading room. Separate offices have been constructed for the Executive Secretary, and some enlargement of the Medical Credit Bureau has been made. The Tulsa County Medical Society now utilizes the entire twelfth floor of the Medical Arts Building.

SPRING REFRESHER COURSE IN OTOLARYNGOLOGY OFFERED

The fifth semi-annual refresher course in laryngology, rhinology and otology will be conducted by the University of Illinois, College of Medicine at the College in Chicago, March 26 to 31 inclusive, 1945. While the course will be largely didactic, some clinical instruction will be included. This course is intended primarily for ear, nose and throat specialists. As the registration is limited to thirty, applications will be considered in the order in which they are received. The fee is \$50.00. When writing for applications, please give details concerning school and year of graduation, and past training and experience. Address Dr. A. R. Hollender, Chairman, Refresher Course Committee, Department of Otolaryngology, University of Illinois, College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

DR. JOHN S. ROLLINS ILL AT ST. ANTHONY

Dr. John S. Rollins of the Rollins Hospital at Prague underwent a serious major operation at St. Anthony Hospital in Oklahoma City on January 20. He is reported as doing well.

AMERICAN COLLEGE OF SURGEONS DEFERS WAR SESSIONS

The American College of Surgeons has deferred for the time being its 1945 series of War Sessions, four of which were to have been held in February, according to an announcement by Dr. Irvin Abell, Chairman of the Board of Regents. Dr. Abell states that plans had been completed for the February meetings because earlier indications were that sessions of a strictly educational nature, limited to relatively small local areas, would be sanctioned by the War Committee on Conventions, but it now develops that the transportation crisis is so acute that even this type of meeting should be omitted in order to help the war effort, and the College is glad to cooperate with the agencies responsible for the movement of military personnel and supplies.

The American College of Surgeons has voluntarily omitted its annual Clinical Congress ever since the United States entered the war, in order to aid the war effort by minimizing the demands upon transportation facilities. The War Sessions were devised as a wartime expedient to preserve the educational values insofar as possible with greatly lessened demands upon hotel and travel services.

The February meetings were to have been held in St. Louis on the 2nd, in Louisville on the 5th, in Milwaukee on the 7th, and in Cleveland on the 27th.

CRITICAL NEED FOR NURSES FOR ARMED FORCES

Hospital Administrators and Doctors Must Do Everything Possible to Release Them for Military Duty

With a critical shortage of nurses for the armed forces — eleven army hospitals are about to go overseas without any nurses — hospital administrators and physicians must do everything they can to help meet this critical need by releasing nurses for military duty, The Journal of the American Medical Association for January 6 declares. The Journal says:

“Mr. Basil O'Connor, chairman of the American Red Cross, sent to every chapter last week an appeal for an immediate maximum Red Cross effort to secure 10,000 additional nurses needed by the armed forces. The rapidly mounting casualties in Belgium demand a maximum of medical and nursing care. Eleven army hospital units, Mr. O'Connor reported, are about to go overseas without any nurses — a condition unprecedented in the history of our country. The war is far from being ended, yet

already the need for careful rationing of nursing service has been demonstrated. That need will intensify in the months to come. The patient load in army general hospitals in the United States has more than doubled in the last nine months without the necessary increase in nurses.

“The Red Cross, in its messages to the public, has emphasized ways in which the public can help in saving nursing service and thus release nurses for military duties. The physician can help by making certain that nurses are assigned only to cases in which nursing service is absolutely essential. The employment of special nurses for any except critical illnesses is unwarranted. Nurses are being used in hospitals occasionally for services other than actual nursing. These are services in which a nurse's aide, a dietetic aide or some similar temporary assistant might be helpful. Doctors know the nurses in their immediate communities. They can help by urging every nurse and retired nurse not eligible for military service to take an essential nursing job and thus to fill the ranks on the civilian front. Doctors can be helpful by urging every registered nurse available for military service to submit an application.

“Practically every American family has at this time a son, a brother or an immediate relative in the armed forces. It takes good nursing to bring about recovery of those wounded in battle. The ratio of nurses in our military hospitals in this country is 1 to every 22 patients and abroad 1 nurse to every 12 patients. In many of our civilian hospitals the nursing staff today is 1 to 3, 5 or 8 patients. The administrators of hospitals can aid greatly by making sacrifices to release some of these nurses for military duties. As Janet M. Geister, editor of the Trained Nurse and Hospital Review, has emphasized, there is not an instance on record of a nurse putting herself on a case. Only doctors and hospital administrators prescribe nursing. The nurse depends on the doctor for her release from civilian duties. As long as the doctor says to her, ‘You are needed here just as much as you are out there,’ she can cheerfully avoid applying for military service.

“Attention must be called particularly to the wasteful use of nursing service at this time by large industries, which keep nurses sitting idle much of the time in first aid stations and industrial dispensaries. The unnecessary full time employment of nurses as bystanders in physicians' offices must also be controlled. Under the stress of war, doctors can well afford to permit women patients to prepare themselves for examination or at least to train the office secretary or attendant in these none too technical duties.

“Latest reports from the Army and Navy indicate that nearly 75,000 nurses have already applied for service with the armed forces, which represents nearly 30 per cent of all active trained nurses in the country. Of the 75,000 nurses who applied, almost 16,000 were rejected. Today there are 47,478 nurses on duty with the Army, and 11,822 were rejected for physical or profes-

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sional reasons. Up to December 1944, 6,641 nurses had been honorably discharged because of medical reasons. In the Navy 15,519 nurses applied for service, of whom 11,499 were assigned to the nurse corps and 4,020 were rejected for physical and professional reasons. Honorable discharges have been given to 3,685 nurses by the Navy, principally because of marriage, as the Navy nurse corps does not accept married nurses. The National Nursing Council for War Service indicates that there are in the United States about 265,000 active nurses of all ages, married and single, and including those with children under 14 years of age. This means that there are still nurses available if the civilian institutions will recognize the need and if hospital administrators and physicians particularly will do everything that they can to release nurses to the armed forces.

Book Reviews

RADIATION AND CLIMATIC THERAPY OF CHRONIC PULMONARY DISEASES: Edited by Edgar Mayer, M.D., F.A.C.P., F.A.C.C.P., with the Collaboration of 22 authors. 393 pages. The Williams & Wilkins Company, Baltimore 1944. Price \$5.00.

An interesting, readable, instructive book, edited by Edgar Mayer, containing 26 chapters with an introduction and a resume by the editor. The 22 contributing authors bring together in one volume much valuable information on radiation and climatic therapy.

The book presents the difficulties so often encountered in compilations including the thought and experience of many contributors, namely, confusing differences of opinion, duplications and the lack of decisive guidance. The reviewer hastens to add that this criticism applies particularly to that portion of the book, approximately one-fourth of the printed matter, devoted to solar radiation and climatotherapy. This is a difficult subject to handle and the editor wisely says in his resume that the selection of climate "is to be made chiefly on the basis of experience." But immediately following this statement he sets an insurmountable task by adding "knowledge of the effects of various climatic influences and an ability to assess them in relation to the person and his disease are essential."

It is heartily agreed that the editor speaks the truth when he says, "too frequently those engaged in treating pulmonary diseases peremptorily disregard the therapeutic possibilities inherent in light and x-ray irradiation as important adjuvants in the management of selected patients."

The chief value of this volume is to be found in the chapters dealing with light and roentgen therapy.—*Lewis J. Moorman, M.D.*

OPERATIONS OF GENERAL SURGERY: Thomas G. Orr, M.D. 723 pages with 1396 step-by-step illustrations on 570 figures. Philadelphia and London. W. B. Saunders Company, 1944. Price \$10.00.

Orr's General Surgery is an excellent volume on surgical technique. Probably of most value to the young surgeon who has not acquired a large library, this single volume of 700 pages is up-to-date, concise, surprisingly complete and definitely usable. The arrangement of sub-

ject material in systems is practical and appeals to the reviewer.

The operations described are the procedures of today, approved and carried out by our foremost surgeons. Wound healing, completely discussed in the first chapter is followed by 21 chapters on subjects of unmistakable importance. The chapter on "The Thorax and Respiratory System" so scantily discussed in most texts, is comprehensive and is coherently illustrated. The space devoted to the "Digestive System," adequate and enhanced by numerous how-to-do-it pictures, is a worthwhile monograph in itself. A rather limited space is devoted to gynecological surgery. However, the most frequent gynecological procedures are described.

This single volume wastes no words. Its arrangement, accuracy of description and 1396 step-by-step operative illustrations make it a worthwhile book for the senior resident and young doctor, as well as the busy surgeon. Thomas G. Orr, Professor of Surgery, University of Kansas School of Medicine, has written in one volume more than is well covered in some other two and three volume sets. "Operations of General Surgery" will be appreciated.—*Gregory E. Stanbro, M.D.*

ARTIFICIAL PNEUMOTHORAX IN PULMONARY TUBERCULOSIS: T. N. Rafferty, M.D.: Introduction by Henry Stuart William, M.A., M.D. 192 pages. Grune & Stratton, New York. 1944.

This little volume of approximately 200 pages constitutes a valuable and timely compendium on artificial pneumothorax. It should be made available to every intern and every house physician endeavoring to learn the principles and techniques upon which this therapeutic procedure rests; it should be in the hands of every young physician who assumes the responsibility of employing pneumothorax in his practice and it should be carefully studied by many experienced operators who have been too busy keeping up with practice to keep up with the progress of our knowledge in pneumothorax.

The author well states the indications and contra-indications and effectively presents the basic principles involved. He clearly distinguishes between effective and ineffective pneumothorax and stresses the importance of prompt decisions, if ineffective, in favor of supplementary aids or abandonment and the employment of other measures. A redeeming feature resides in the fact that no doctor can read the book without discovering that being able to introduce the needle and read the manometer does not qualify one for the successful administration of artificial pneumothorax.

In the introduction by Henry Stuart Willis, we find these pertinent words, "It notes the great advantages that accrue from pneumonolysis. It stresses complications and suggests that these are rare in cases where indications and contraindications are sharply defined and observed, where pneumonolysis is done wisely, early, and well, and where pneumothorax is regarded as an exploratory procedure, to be abandoned immediately after its inadequacy is demonstrated and before harm can ensue. It pays particular attention to the causes, prevention, and treatment of empyema. When one has perused these pages he is tempted to feel that complications can no longer be regarded as just one of these things that happen or can seldom be excused as an act of God. Rather, the operator will come to think of them as a likely reflection on his judgment or his technique."

The illustrations are well chosen and they effectively illuminate the text.—*Lewis J. Moorman, M.D.*

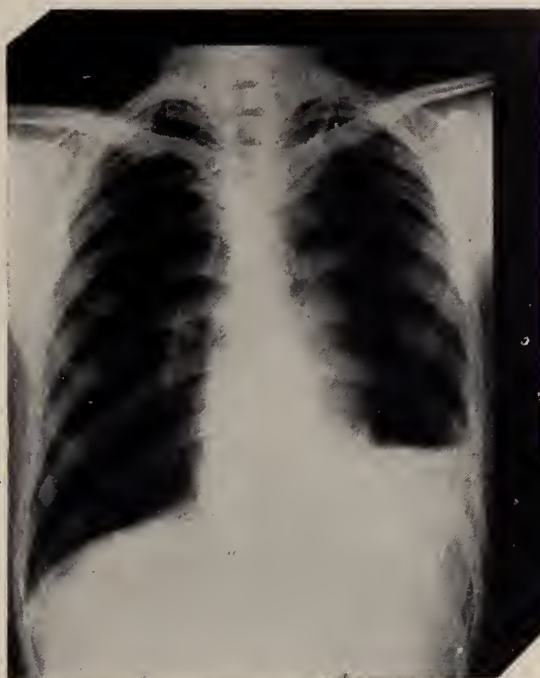
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SPECIAL ARTICLE

Preserve Present System Of Medical Care

ADRIAN H. SCOLTEN, M.D.

PORTLAND, MAINE

Much has been said to convince the Medical Profession and the Public whom they serve that State or Socialized Medicine will become a reality in America. Those who have been reading extensively on the subject and who have practiced under State Medicine or where Medical Insurance plans are in operation believe that the present system of medical care as it is practiced in Maine today is far superior to any plan yet proposed or in operation in this country or elsewhere.

Before we accept any other plan, we should be convinced that there is need for a change and that this change will be for the best interests of the patients and to the best interest of the Medical Profession. Without the hearty cooperation of the medical profession, no medical service plan can be a success. Neither State or Socialized Medicine or any insurance plan can ever be put into operation unless a majority of the medical profession gives its approval and consent.

Before we give up our independence in Medical Practice and adopt a Medical Insurance Plan — because we fear that the bill authorizing State or Socialized Medicine will be passed by the Federal Government — we should know something of the strength of the opposition to the passing of the Wagner-Murray-Dingell Bill. The opposition comes from all walks of life. Several pages could be filled with quotations, but I can use here only a few:

Senator C. Wayland Brooks, of Illinois: "The Medical Profession has done an outstanding job and should not be brought under the whims of bureaucracy. There is strong opposition being voiced at present to such legislation. By the passage of necessary war measures, many Constitutional rights of the citizen have been temporarily suspended. To establish a system which would make these powers permanent is not appealing to many members of the Congress."

Dr. Fishbein, Editor of the Journal of the American Medical Association said on March 24, 1944, in Terre Haute, Indiana: "Regarding the Wagner-Murray-Dingell bill, which is known as the bill for 'Socialized' Medicine, it has never aroused any extravagant enthusiasm in this part of the country. American medicine has produced the lowest death rate, and the most advanced medical science in the world. The chief incentive of the scheme seems to be a life pension for everyone in medical practice, keeping a lot in that shouldn't be there, and the building up of a regimented profession with gigantic financial reserves which will be under the control of a politically appointed poohbah. The nation appears restless under the operation of some other things in the same direction."

In Columbus, Ohio, on April 4, 1944, Dr. Fishbein said: "America's leadership in the medical world is being threatened by proposed legislation that would set up bureaucratic control of the Medical Profession."

"American medicine leads the world today and will retain that leadership in the post-war world," Dr. Fishbein said in an address before 200 members of the Columbus Academy of Medicine and their wives at a dinner meeting at the Seneca Hotel in honor of the academy's past presidents and 50-year members.

"The legislation," Dr. Fishbein asserted, "if enacted would have a bureaucracy in Washington abolishing a patient's free choice of physicians, would determine which hospitals would be acceptable for government funds, and would discriminate against certain medical schools."

Again in Toronto, Canada, Dr. Fishbein said: "The state frequently endeavors to control disease through the exercise of the police power, but that compared with individual treatment by individual physicians applying specific remedies is a costly and inefficient procedure."

"There is no evidence that the medical bureaucracy which would be set up would give the kind of service that Americans have come to expect," he added.

"He termed the bill fallacious and out of accord with the American system of government."

The following is quoted from the April 25, 1944, Bulletin of the A.M.A.'s Council on Medical Service and Public Relations, G. Lombard Kelly, Secy.

Congressman Dingell, co-author of the current Wagner Bill, recently stated that the opposition came from a "reactionary minority in the medical fraternity." Note particularly that word "Minority," and then take a look at the record. There are 295 practicing physicians in Congressman Dingell's home district in Detroit. They were polled with this result: 10 were in favor, 9 were undecided, and 265 were against the bill.

In Senator Murray's state, Montana, the third co-author of the Bill was deserted by the members of the medical profession. There are approximately 400 doctors of medicine in the state, and all but one county medical society voted unanimously against the bill.

We are living in a period when social reformers, economists, hospital insurance associations, and government agencies are striving for means to control the practice of medicine. Some are more interested in what they can get out of it than in the welfare of those persons whom they profess to serve.

The reactions of some members of the medical profession in California where a pre-payment plan known as the California Physicians' Service is in operation are reflected by the magazine, California and Western Medicine.

Morton R. Gibbons, Sr., M.D., Medical Director of the California Insurance Plan, wrote in this magazine recently: "You must be more or less familiar with the '57 varieties' of state medicine in existence at last reports. Most of the important countries of the old world have had state medicine, in some form. No two were alike, the best reason for which is that none was satisfactory. At last report, Germany's system — the oldest — reported that absence due to sickness increased 40 per cent. Physicians' incomes were so meagre that suitable young men would not study medicine. England did not wish to abolish her system, but hoped it could be much more satisfactory, yet did not know how it could be improved."

Dr. Morton R. Gibbons, Sr., also said in his report in the California and Western Medicine: "This country (America) never adopted state health insurance, because the people naturally want to be independent. Lately, that attribute (independence) is being worn down — unless recent elections mean something."

"The Wagner-Murray bill provides for control of the whole problem by the U. S. Public Health Service. Doctor Parran told me that he had no inkling of this bill until it was shown to him the day before it was introduced. He said he would have none of it. The Public Health Service views it with horror. The bill is probably too great a bite to take all at once, and therefore will defeat itself. It is another example of an effort to attain fulfillment of a delightful dream without knowledge of the obstacles in the path."

"I cannot leave consideration of 'what we have' without reference to the Workmen's Compensation Laws (California's especially). The California law has attributes comparable to state health insurance. This law went into effect thirty years ago. It has been modified, altered, amended, not because of changing conditions, but because it was not perfect. It is not perfect yet. It was at first administered by high-minded men. It has been from time to time dominated by politics and administered in a manner quite contrary to its intent, and the wishes of the people."—*Morton R. Gibbons, Sr., California and Western Medicine issue.*

Under any state medicine or even an insurance plan, doctors may have to spend as much time making out blanks and justifying their actions to a Board of Directors or to the Administrator of the Plan as in treating their patients. The present privacy existing between the patient and the doctor will be gone. Confidential matters will be on record outside of the doctor's own office. Today what the patient tells the doctor is completely confidential, and a patient trusts his doctor as much as he does a member of the clergy. Today he need fear no leaks.

The question also arises whether so drastic a change should be made when so many doctors are in the armed forces and have no opportunity to vote for or against it. Conversation with doctors in the armed forces in this country and letters from those in foreign countries support the conviction that they wish to come back to the present free and unregimented way of practicing medicine. They are fighting a war in order that America may be kept free from dictation. They, like those of us who were in the last war, have had more than their fill of regimentation and dictation. They long to go back to independent living and freedom of enterprise.

California, during its early experience in the field of Voluntary Medical Insurance found itself short \$1,350,000. The insurance charge to the patient each month was not high enough and the doctors were forced to take one-half their promised fee.

Many California doctors and their patients are not enthusiastic about the California Physicians' Service. Even now after five years of experience, many physicians and patients wish they had never been sold on the idea.

What is back of all this propaganda for Socialized Medicine or Voluntary Medical Insurance, its substitute measure? This is something which only those who are "in the know" can answer.

In three years of Post Graduate study in New York City, just before we were pushed into this war, I was daily associated with well-trained, high-minded refugee physicians, some of whom were deeply thankful that they could live and practice in a freedom loving country where there was no "middle man" to interfere with the doctors' judgment, and whose salaries and overhead must be added to medical costs.

We have to admit that the most efficient form of government is a dictatorship, but Americans do not want it. There is an uncanny wisdom in the Voice of the People, and in our Democratic procedures. Our present method of Medical practice should be preserved because it is more simple, more direct, and more satisfactory than any of the imported European varieties. European idealogies cannot successfully be foisted upon the American people.

Under our time-tried medical practice, American physicians and surgeons have enjoyed unrestricted freedom and independence yet they have led all other countries in giving consistently high quality medical service to all the people without fear or favor, and to the indigent, without price.

American doctors have the respect and confidence in their patients and a record of achievement which is unequalled.

We have a noble heritage. We must seek to remain free in our thinking, unrestricted in our ways of doing, and as unmolested by bureaucracy and outside dictation as is possible.

OUR RIGHTS

The right "to a decent home" — to "a good job" and "good medical care" is not new to the American people. It appears that the New Dealers have suddenly discovered these rights which to us have always existed as inherent virtues of the American way of life. Some day it may be discovered that everybody has a right to be president, but not without effort.

This profligacy with other people's profits is not new, neither will its dire effects surprise the students of history. This is not a lesson in history but for the purpose of illustrating our point, we look backward two thousand four hundred years and quote from "The Plutus" written by Aristophanes. The atmosphere of the lyrical plays was gone, the Periclean age had passed. The glory that was Athens was on the wane; the fine instincts and splendid ambitions of the Fifth Century B. C. were on the way out. Apparently the policies now championed by the New Dealers, were driving old Aristophanes to the point of dramatizing their evils. The god of wealth dominated the treasure-chamber of the parthenon and the ancient problem "why do the ungodly prosper, while the righteous are needy and poor" was troubling the people. In his allegory "The Plutus" Aristophanes justifying answered this question by assuming that wealth is blind. In the controversy between wealth and poverty, the latter throws the spotlight on the evils of our present socialistic trends. Medicine also comes into the dialog between Blepsidemus and Chremylus. Evidently Hippocratic medicine had shared in the general decline only to be recovered by Galen 500 years later.

Blepsidemus: Had we not better call a doctor in?

Chremylus: Is there a doctor now in all the town?

There are no fees, and therefore there's no skill.

Blepsidemus: Let's think awhile.

Chremylus: There's none.

Blepsidemus: No more there is.

Chremylus: Why then, 'tis best to do what I intended, To let him lie inside Asclepius' Temple A whole night long. . . .

Wealth, blind, if sight regained, would he bestow a boon on mankind? Poverty retorts as follows:

Poverty: Why, if Wealth should allot himself equally out (assume that his sight ye restore),

Then none would to science his talents devote or practice a craft any more.

Yet if science and art from the world should depart,

pray whom would ye get for the future

To build you a ship, or your leather to snip, or to make you a wheel or a suture?

Do ye think that a man will be likely to tan, or a smithy or laundry to keep,

Or to break up the soil with his ploughshare, and toil

the fruits of Demeter to reap,

If regardless of these he can dwell at his ease, a life without labour enjoying? . . .

Poverty: No more on a bed will you pillow your head, for there won't be a bed in the land,

Nor carpets; for whom will you find at the loom,

when he's plenty of money in hand?

Rich perfumes no more will ye sprinkle and pour

as home ye are bringing the bride,

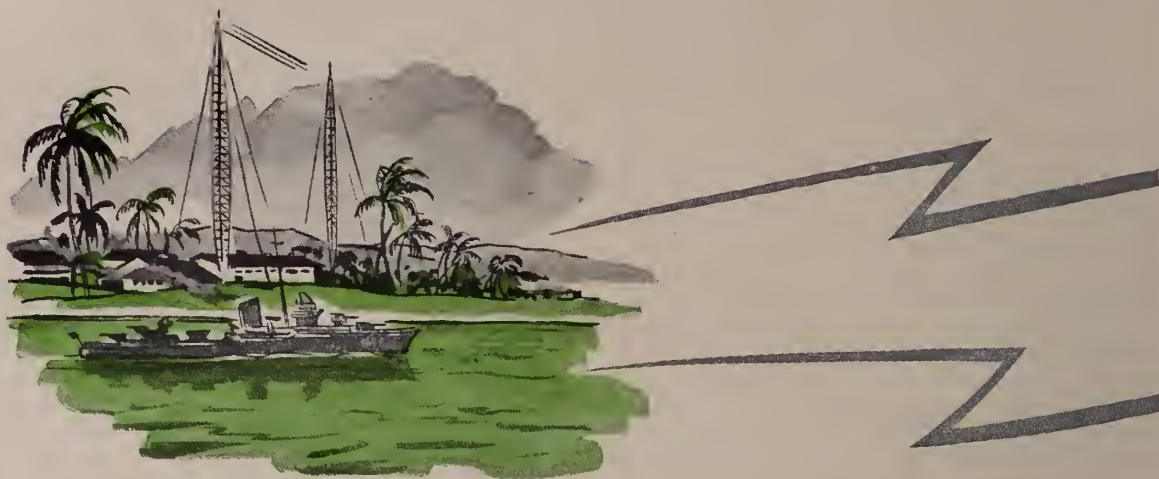
Or apparel the fair in habiliments rare so cunningly fashioned and dyed.

Yet of little avail is your wealth if it fail such enjoyments as these to procure you.

Ye fools, it is I who alone a supply

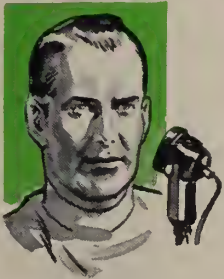
of the goods which ye covet ensure you.

Must patients and doctors give up their liberty and permit the bureaucrats to start them on the road back more than two thousand years for a night in the temple, with the hope of a healing dream or that the snakes may crawl out of their holes and lick their lids.



The details of this dramatic story were reported in daily newspapers on December 6, 1944—a tribute to the skill and ingenuity of the physicians in our Armed Forces.

RÂLES by RADIO



"Your man has an asthmatic attack . . . wrap him in blankets with hot water bottles and give him an injection of Adrenalin Chloride"

Spanning hundreds of miles of ocean, these life-saving directions of a Navy doctor in Hawaii were carried by radio to a small vessel "somewhere in the Pacific" on which a seaman lay unconscious. A stethoscope over the patient's chest with ear pieces pressed close to the microphone had made it possible for the physician to hear the breath sounds and heartbeat in Honolulu.

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Its ability to relax spasms of bronchial musculature, to stimulate the heart with increase in cardiac output, to raise systolic arterial pressure and widen pulse pressure, and to constrict blood

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With some of the same inevitability you will insist upon a thoroughly reliable solution of liver. For therein lies the effectiveness of your treatment.

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To know this is to know that, with the help of your treatment, life for your patient may once again regain much of its fulness . . . his cup once more be brimming.

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Medical School Notes

Dr. H. A. Shoemaker returned recently from a trip to New Orleans, Louisiana, where he attended the conference of the screening committee for the Naval V-12 Program in the Eighth Naval District. He left January 2, returning on January 6. Returning via Dallas, Dr. Shoemaker also conferred with Army Officers and discussed plans for government purchase of textbooks for all A.S.T. students.

Dr. Ernest Lachman spoke on "Recent Advances in the X-Ray Diagnosis of Disease," at a meeting of the Cleveland County Medical Association.

Dr. Kenneth M. Richter addressed the University of Oklahoma Chapter of Sigma Xi in a meeting held December 12 at the Biology Building in Norman. He spoke on "Changes in Blood Leukocytes."

Inspection of A.S.T.U. 3865, first Student Training Company, was held from January 12 to January 13. It was conducted by Major Carl E. Anderson, Infantry, who represented Major General Wiebel of the Army Service Forces, Washington, D. C. Remarking that the unit at the University of Oklahoma School of Medicine, in comparison to other similar units was among the best in the nation, the Major seemed well pleased with the results of the inspection.

Dr. Ernest J. Lachman, Associate Professor of Anatomy, has been promoted to Professor of Anatomy and Chairman of the Department of Anatomy, effective February 1, 1945.

Dr. Charles E. Leonard, who formerly held the Rank of Assistant in Medicine, has been appointed Instructor in Psychiatry.

At the meeting of the Board of Regents on January 10, 1945, Dr. Charles B. Taylor was appointed Professor Emeritus of Urology. Dr. Taylor has rendered twenty-five years of service to the University of Oklahoma School of Medicine and Hospitals.

Dr. Basil A. Hayes has been promoted to Professor of Urology and Chairman of the Department of Urology, effective January 1, 1945.

Recent visitors at the School of Medicine: Major John P. Wolff, formerly a lecturer in surgery and now in the South Pacific Theater of War. Major William K. Ishmael, on leave of absence from the Department of Medicine, spoke to the Senior Class. Lt. Col. Glen W. McDonald, graduate of 1934.

Success in your work, the finding a better method, the better understanding that insures the better performing is hat and coat, is food and wine, is fire and horse and health and holiday. At least, I find that any success in my work has the effect on my spirits of all these. Perry, Bliss. *The Heart of Emerson's Journals*, page 318. Boston and New York.

I went to Washington and spent four days. The two poles of an enormous political battery, galvanic coil on coil, self-increased by series on series of plates from Mexico to Canada and from the sea westward to the Rocky Mountains, here terminate and play and make the air electric and violent. Yet one feels how little, more than how much, Man is represented there.—Perry, Bliss. *The Heart of Emerson's Journals*, page 197. Boston and New York.



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SQUIBB

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NEWS FROM THE COUNTY SOCIETIES

Cleveland

Dr. Iva Merritt, Norman, was elected President of the Cleveland County Medical Society on January 11 at a meeting held at the Central State Hospital. Other officers elected were Dr. W. H. Atkins, Vice-President, and Dr. O. M. Woodson, Secretary-Treasurer.

Dr. Vern Musick, Oklahoma City, was guest speaker. He talked on the "Treatment of Peptic Ulcers."

Garfield

The following officers for 1945 have been elected by the Garfield County Medical Society: President, Dr. W. P. Hopkins, Enid; Vice-President, Dr. F. M. Dnffy, Enid; Secretary, Dr. John R. Walker, Enid.

Grady

The Grady County Medical Society met on January 11 in Chickasha with twelve members present. The purpose of the meeting was the election of officers which was as follows: President, Roy E. Emanuel, Chickasha; Secretary, Rebecca Mason, Chickasha; Delegate, Walter J. Baze, Chickasha.

The next meeting was a Bi-County meeting of the Grady County Medical Society and the Caddo County Medical Society, to be held on January 18.

Logan

Newly elected officers of the Logan County Medical Society were announced January 20. Dr. J. L. LeHew was elected President; Dr. R. F. Ringrose, Vice-President; Dr. J. E. Sonther, Secretary-Treasurer, and Dr. C. B. Hill, Dr. P. B. Gardner and Dr. W. C. Miller, Censors. Dr. L. A. Hahn was chosen as Delegate to the State Convention.

Okfuskee

Newly elected officers of the Okfuskee County Medical Society are as follows: Dr. W. P. Jenkins, President; Dr. L. J. Spickard, Vice-President; Dr. M. L. Whitney, Secretary-Treasurer; Dr. A. S. Melton, Delegate. Dr. Whitney was also chosen as Alternate and Dr. Spickard was named Censor.

Okmulgee

On January 8 the Okmulgee Medical Society installed the officers for the year 1945, who were elected at the December 14 meeting.

The following scientific program was presented. Dr. Joseph Fulcher, Tulsa, spoke on "Newer Methods in the Management of Certain Proctological and Neurological Maladies." Dr. W. A. Showman, Tulsa, spoke on "Skin Diseases of the Lower Extremities." Dr. Hugh Evans, Tulsa, reviewed an article by Lt. Col. John E. L. Keyes that appeared in the A.M.A. Journal of November 4, 1944; the article was entitled "Penicillin in Ophthalmology."

Ottawa

The regular meeting of the Ottawa County Medical Society was held on January 18 at the Miami Baptist Hospital in Miami. The speaker of the evening was Dr. M. F. Hall of Joplin, Missouri, who spoke on the use of the X-ray in the treatment and prognosis of many malignant and other diseases. The paper was discussed by Dr. McNughton of Miami.

Tulsa

The Bulletin, official publication of the Tulsa County

Medical Society, has been given an attractive new color cover and will be enlarged shortly to provide for additional advertising contracts. Physicians of Oklahoma City and central portions of the State have been added to the mailing list.

Washington-Nowata

On January 10, Dr. C. R. Rountree, President of the Association outlined the Legislative Program as he addressed the annual ladies' night and installation banquet of the Washington-Nowata County Medical Society. Dr. Rountree discussed the Board of Health Bill, the Medical Examiners System, the Medical School Appropriation and the Post War Training Plan.

Dr. J. V. Athey, Bartlesville, new President of the Society, who was its Secretary for 20 years, gave a short history of the group which was formed in 1908. Three doctors who attended the first organization meeting were present, Drs. O. S. Somerville, J. G. Smith and H. C. Weber. They were called on to give short reminiscent speeches. Smith said in those days that there were no office girls, a doctor didn't have to stay in his office and the hunting and fishing were good.

Tribute was paid to the staff of Memorial hospital, the nurses aides and to the nurses who had come out of retirement to assist during the present crisis.

The following committees for 1945 were announced: Drs. O. I. Green, J. G. Smith and L. D. Hudson as members of the Public Health and Legislation Committee, and Dr. B. F. Staver, Thomas Wells and J. P. Vansant as the Entertainment and Program Committee. Dr. Davis of Nowata, retiring President, gave a resume of the Society's 1944 activities.

Preceding the banquet, doctors, their wives and guests attended a reception at the Weber home in honor of Dr. and Mrs. Rountree.

Obituaries

Leigh D. Gillespie, M.D. 1869-1945

Dr. Leigh D. Gillespie, Ardmore, died unexpectedly, of a heart attack, on January 4.

Dr. Gillespie was born at Gatesville, Texas, received his medical education at Baylor University College of Medicine in Dallas, graduating in 1904. For the past forty years he has been a practicing physician at Springer, Gene Autry and Ardmore. Dr. Gillespie was a member of the Carter County Medical Society, the Oklahoma State Medical Association and the American Medical Association. He was also a member of the Masonic lodge of Ardmore.

Surviving Dr. Gillespie are his wife Ellen, two daughters, Mrs. Ethel Booth, Oklahoma City and Mrs. Era Mitchell, Providence, R. I.; two sons, W. W. Gillespie, Ardmore and Charles Gillespie, Gene Autry.

Members of the Carter County Medical Society served as pallbearers. The remains were taken to Coryell County, Texas and interment was in the Flint Creek Cemetery.

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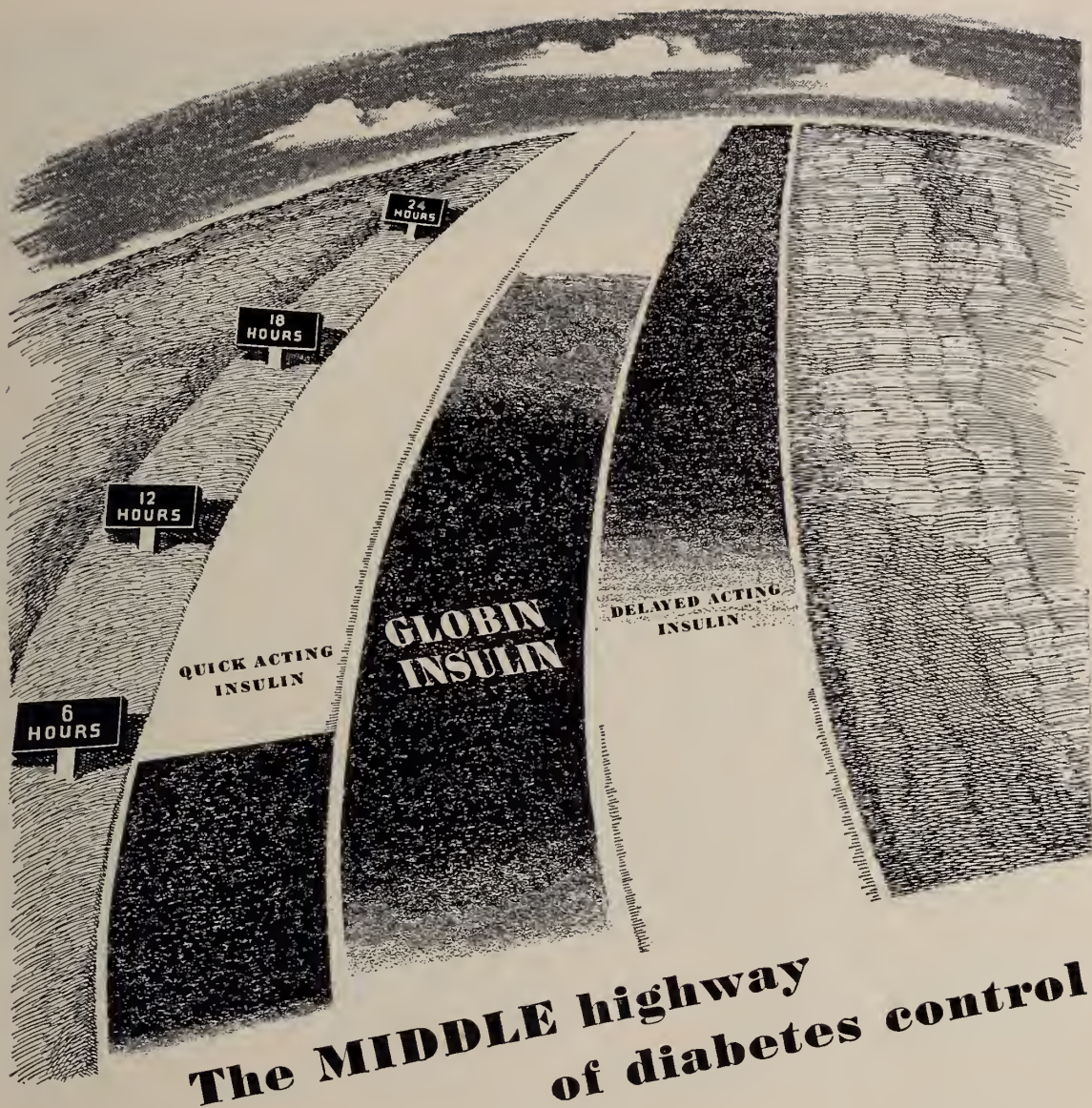
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erties, is comparable to regular insulin. It is accepted by the Council on Pharmacy and Chemistry, American Medical Association, and was developed in the Wellcome Research Laboratories, Tuckahoe, New York. U. S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc.

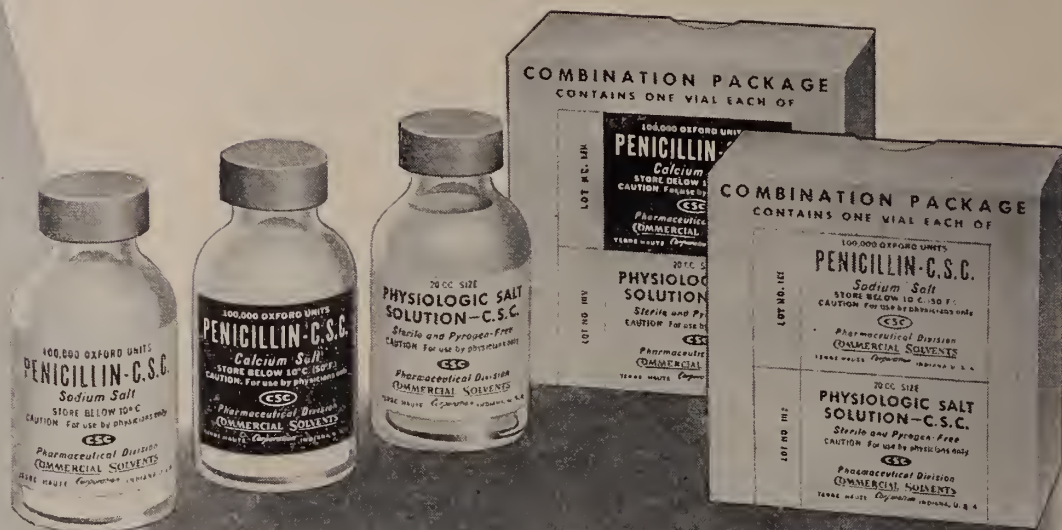
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For the usual concentration (5000 Oxford Units per cc.) inject 20 cc. of physiologic salt solution into the vial in the usual aseptic procedure.



Invert the vial and syringe (with needle in vial), and withdraw the amount of penicillin solution required for the first injection.



Store vial with remainder of solution in refrigerator. Solution is ready for subsequent injections during the next 24 hours.

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For administration in the physician's office or in the patient's home, Penicillin-C.S.C. will be available in a convenient combination package, as soon as the drug is released for unrestricted use in civilian practice. This combination package provides two rubber-stoppered, serum-type vials. One vial contains enough physiologic salt solution to permit the withdrawal of 20 cubic centimeters. The other vial contains 100,000 Oxford Units of penicillin sodium or penicillin calcium* respectively.

The physiologic salt solution is sterile and free from fever-producing pyrogens. Penicillin-G.S.C.—whether the sodium salt or the calcium salt—is bacteriologically and biologically assayed to be of stated potency, sterile, and free from all toxic substances, including pyrogens, as attested by the control number on the package.

When 20 cc. of the physiologic salt solution is withdrawn from its vial, and injected into the penicillin-containing vial under the usual aseptic precautions, the resultant solution presents a concentration of 5000 Oxford Units per cubic centimeter. The solution is then ready for injection, does not require resterilization.

After the desired amount of the solution for the first injection has been withdrawn, the vial containing the remainder of the solution should be stored in the refrigerator. It is ready for the next injection—the desired amount then merely has to be withdrawn under proper sterile technic.

When released for unrestricted marketing, Penicillin-C.S.C. will be stocked throughout the United States by a large number of selected wholesalers. Any pharmacist thus will be able to fill professional orders promptly.

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*Penicillin calcium, equal to penicillin sodium in therapeutic efficacy and nontoxicity, in recent investigations has been shown to be less hygroscopic than the sodium salt, and somewhat more stable. Both forms of the drug should be stored in the refrigerator, at a temperature not over 50° F. (10° C.).

[illegible]

A page of the "Penicillin-C.S.C. Therapeutic Reference Table," showing recommended dosages and modes of administration; a copy is yours for the asking.

★ FIGHTIN' TALK ★

Edwin C. Yeary Reported Missing in Action

CAPTAIN EDWIN C. YEARY, Oklahoma City, has been reported by the War Department as missing in action in Belgium since December 19. Further details have not been received.

Captain Yeary graduated from the University of Oklahoma School of Medicine in 1939 and served internships at the University Hospital of Iowa and Midway Hospital at St. Paul. He entered the service in June, 1941, going overseas in September, 1943.

COMDR. COY ABERNETHY, Altus, Class of '30, has been assigned to the Naval convalescent hospital at Banning, California. He has completed a year of duty as a Naval doctor aboard a battleship in the Pacific.

JAMES L. TEDROWE, son of Dr. and Mrs. C. W. Tedrowe of Woodward, is missing in action in the Philippines where he was serving as bombardier on a search plane. He went overseas in August, 1944.

MAJOR KENNETH E. HUDSON, Oklahoma City, formerly of the Surgeon General's Office has been assigned to the 8th Service Command, Army Ground and Service Forces Redistribution Station at Fort Sam Houston, Texas.

CAPTAIN WILLIAM H. SHOFSTALL, Oklahoma City, writes from his overseas station, in part:

"We have been over here in France for quite some time now and it looks as if it will be for a while longer, so I expect that many of us are going to need some extra work when we get home to be able to know enough to do anything in the various fields of medicine.

"Have been to Paris a few times on business but at the same time seen a bit of the city which is quite grand from all outside appearances. I could see where it must have been lots of fun in peace time.

"I wish you all, my friends, a Very Merry Christmas and a Very Happy New Year, with many more to come. Joyeux Noel."

MAJOR LOUIS CHARNEY, Oklahoma City, is now stationed at a large hospital in France where he is Assistant Chief of Medical Service and Chief of the Cardiovascular and Gastrointestinal Sections. He has been elected to several boards. He says that he is more than pleased with his present assignment as the hospital is a wonderful place and is well equipped.

Living conditions, too, have improved with this assignment. The quarters are in a former German Officers Club and the luxury of real beds, real hot water and other nice things of the past are in evidence. Major Charney says:

"This hospital is part of a school of medicine. The school is several hundred years old and claims some of the outstanding French physicians. In their museum which I viewed yesterday are specimens and manuscripts written by the most outstanding French doctors. I read one of Launois manuscripts — the original — and it is truly wonderful."

"Just finished our medical meeting and it was very interesting. This night was our 'Journal Night.' On this night the Journals are divided among the crowd and reviewed. I reviewed the Annals of Internal Medicine and for my main subject for discussion I picked Dr. Lewis J. Moorman's subject on Hemoptysis in Tuberculosis, with a differential discussion of other causes. We discussed his article for an hour and you can tell Dr. Moorman that in this wonderful hospital he and his

subject were the center of attraction and his article was well taken."

LT. J. ROBERT WALKER, Enid, is now stationed at Walter Reed Hospital after having taken a special course in Anesthesia at the Army Medical Center.

Two Doctors, Oklahoma Graduates, Rescued from Japanese Prison Camp

Thursday, February 1, brought the long-awaited news of safety for two of Oklahoma University School of Medicine graduates, MAJOR RALPH W. HUBBARD, Oklahoma City and MAJOR EMIL P. REED, son of Dr. Horace Reed of Oklahoma City.

The good news reached Dr. John C. Hubbard, father of Dr. Hubbard, at his hospital as he was preparing for an operation. The message was quickly relayed to Mrs. Ralph Hubbard and in turn to Dr. Hubbard's two sons, Joe, age 6 and Ralph, Jr., age 17. Mrs. Hubbard said, "I hardly dared breathe the hope that my husband was one of the lucky men to be rescued."

Major Hubbard, graduate of O. U. in 1932, entered the service in September, 1940. He was captured by the Japanese April 8, 1942, after the fall of Bataan. The only word received by his family since that time were the prison cards which arrived about every 6 months and contained very little information. The last message was received three weeks ago and was dated May 4, 1944.

Major Reed, graduate of O. U. in 1931, practiced in Brownsville, Texas, before entering the service in 1940. He, too, was captured after the fall of Bataan.

Dr. Horace Reed, Oklahoma City, is wearing a firmly attached smile of happiness these days. Major Reed's wife and three children live in Dallas, Texas.

LT. COL. CHARLES R. RAYBURN, Norman, formerly assistant superintendent of Central State Hospital, has been honorably discharged from the Army. He will resume his duties at the hospital.

LT. COL. CANNON A. OWEN, Oklahoma City, commanding officer of a medical battalion somewhere in France, has a new son, David Bostick Owen, born December 13. Lt. Col. and Mrs. Owen have another son, Cannon Armstrong II, age 3.

Lt. Col. Orville Tackett Visits Executive Office

The Executive Office recently had the pleasure of a visit from LT. COL. ORVILLE H. TACKETT, who was home on a 30 day leave from the Caribbean Defense Area where he is General Staff Surgeon of a hospital where tropical diseases are of main concern. CAPTAIN W. R. CHEATWOOD, Alva, is stationed in the same hospital. Col. Tackett has been stationed in this area for the past three years, having had one previous leave in June, 1943.

Col. Tackett says that it is very hot in the country where he has spent the last three years and he has been anticipating the cold, crisp breezes (?) of Oklahoma. He is very glad to be back and says that Oklahoma looks plenty good and that this Christmas was one of his happiest. He is visiting his family who live at 3425 N. W. 19th St., in Oklahoma City. He has two sons, Richter 9 and Orville H., Jr., age 3.

During the few "off duty" hours, Col. Tackett has made trips to Panama, Argentine, Columbia, Peru, Costa Rica, Cuba, Jamaica, Nicaragua and Guatemala. During his travels he has made a collection of hand carved, ivory inlaid, bamboo and other unusual types of furniture which he has shipped home. He has also collected some museum pieces of cloisonne and china.



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Often, superabundant ingestion of protein-rich food fails to influence a negative nitrogen balance, since nitrogen requirement is not only quantitative, but also qualitative. Among the factors determining the nutritive value of a protein food are its digestibility . . . availability of its amino acids . . . ability of the individual to assimilate the food ingested.

Tests show that intact protein introduced directly into the jejunum, requires 40 to 50 minutes for complete absorption, while protein hydrolysate introduced in the same manner practically disappears completely in 15 to 25 minutes***

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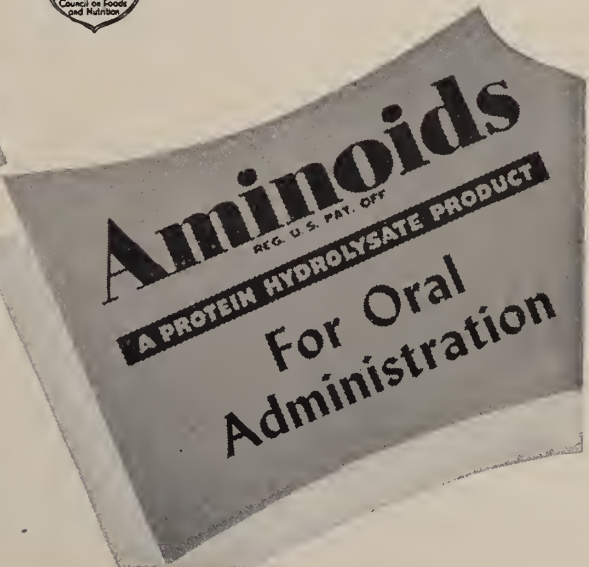


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**McGee, L. C., and Emery, E. S., Proc. Soc. Exptl. Biol. and Med., 45,475 (1940).

Col. Tackett graduated from O. U. in 1939 and served his internship in St. Anthony Hospital. He entered the service immediately after serving his internship and was sent to his present location. He says, "I wish to say hello to everyone that I didn't get to see while home — 30 days is a mighty short time. I would like to hear from any of you who might have time to write."

COL. CHARLES A. PIGFORD, Tulsa, has recently been awarded a full colonelcy. He is now stationed at Fort Sam Houston with the Medical Corps. Col. Pigford practiced in Tulsa from 1937 to 1939, when he was called to active duty.

LT. COMDR. ELMER RIDGWAY, Oklahoma City, has recently been promoted. He is stationed at the U. S. Naval Air Station, Daytona Beach, Florida, after having served two years in the Southwest Pacific Area.

CAPTAIN JAMES D. HUSKINS, graduate of '38, formerly of Wilburton, has been awarded the Bronze Star for fearlessly exposing himself to enemy fire in order to evacuate wounded soldiers. The concluding paragraph of the citation reads: "Many times his skill as a surgeon saved the lives of men of his unit. His courage and inexhaustibility were a contributing factor to the great work done by aid men under his command."

Capt. Huskins practiced at Siloam Springs, Arkansas, after serving his internship at the University of Wisconsin.

LT. WILLIAM C. McCURE, Oklahoma City, writes from his station "somewhere" in the Southwest Pacific and says that he is still thinking about the old home town. He had a pretty nice Christmas in camp and says "we managed to dispel the gloom somewhat as there was adequate 'Christmas cheer' for all."

By other means, the following citation came to the office:

"In the name of the President of the United States, the Commanding General, Fleet Marine Force, Pacific, takes pleasure in awarding the Bronze Star Medal to Lt. William C. McClure, M.C., U.S.N.R., for service as set forth in the following:

"For meritorious achievement in action against the enemy as regimental surgeon of a Marine Infantry regiment on Saipan, and Tinian, Marianas Islands, from 15 June to 10 August, 1944. By his cool and capable handling of evacuation facilities and by his experience in the care of the wounded, he was largely instrumental in saving the lives of many badly wounded Marines who might otherwise have died. He displayed great coolness under fire and his conduct throughout was in keeping with the highest traditions of the United States Naval Service."

s / H. M. Smith

Lt. General, U. S. Marine Corps.

Captain T. J. Huff Missing in Action

CAPTAIN T. J. HUFF, Walters, has been reported by the War Department as missing in action in Luxembourg since December 19. Captain Huff is a graduate of the Class of '42, entering the service in August, 1943.

London, (last week in March) 1848

Richard Owen. Mr. Richard Owen was kind enough to give me a card to his Course of Lectures before the Royal College of Surgeons, and I heard as many of the lectures as I could. He is an excellent lecturer. His vinous face is a powerful weapon. He has a surgical smile, and an air of virility, that penetrates his audience, a perfect self-command and temperance, master of his wide nomenclature, and stepping securely from stone to stone.—Perry, Bliss. The Heart of Emerson's Journals, page 230. Boston and New York.

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Woman's Auxiliary

The strength of a nation is best measured in its steadfastness in wartimes — and, with a total of 276 paid up members, it is with pride that we point to our five remaining Auxiliary Chapters: Oklahoma City, Tulsa, Norman, Ada and Shawnee. From these examples, in their loyalty and devotion to the purpose of being a true aid to the medical profession, and keeping alive the traditions of the Oklahoma State Medical Auxiliary, while at the same time serving their community and nation, in both medical and war efforts, we hope to persuade our chapters that have disbanded, to re-organize. We can readily understand why in the thinly populated western part of Oklahoma with the members having to travel such distances to attend meetings, that their temporary loss is truly our casualty of the war effort. But for the other chapters, I wish to make a plea now for their re-organization.

We feel that today, more than ever before, the Medical Auxiliary can and should be of marked direct help to the war effort in actual deeds of service, as well as in spirit, and taking direct part in the fight against socialized medicine, particularly being prepared to explain the aims and purpose of the state medical insurance plan as now endorsed by the State Medical Society, and on the home front, taking the burden off the over-worked doctor. This is best accomplished through organization, and no organization is closer to the Medical Society than its Auxiliary. Oklahoma City and Tulsa chapters of the Auxiliary have shown in their various services, with which we are all familiar, what an organization can do, and I am happy to say our smaller chapters are cooperating with their communities in every way possible. It is for this reason, we plead with our other chapters to return and become a potent working group in its community.

Even the National Auxiliary, in order to strengthen its organization and sphere of activity, at its meeting in Chicago last July changed its by-laws, re-organized and streamlined its structure. But, the National organization depends on the state, the state organization on its chapters, and the chapters on the individual members. So, to every doctor's wife in the state, I want to reiterate this plea for organization.

The National Auxiliary stresses the need of our support for Hygeia and I am happy to be able to say that with our reduced membership we are keeping our percentage quota of these subscriptions. Thus, I say we may justly feel proud, not only of the maintenance of our organization, but of its activities as outlined. However, it is my sincere prayer, that we not only keep our shoulder to the wheel, but if at all possible, add to our organization both in membership and chapters as well as in service.

And, in conclusion, may I express my thanks for the whole-hearted support each doctor's wife, whether in an active chapter or not, has, and is, giving to the State Medical Auxiliary in its activities, purpose, officers and working organization.

Sincerely,

Mrs. C. C. Young, President.

SENATE SUBCOMMITTEE ISSUES AN INTERIM REPORT ON HEALTH

Journal Says Emphasis Placed on Planning and Control of Programs by the States Is Especially Significant

The emphasis placed on state planning and control in the field of health by the interim report of the Senate Subcommittee on Wartime Health and Education, which has just been issued, is especially significant. The Journal of the American Medical Association for January 6 declares in an editorial. The Journal says:

"The Senate Subcommittee on Wartime Health and Education, a subcommittee of the United States Senate Committee on Health and Labor, has just issued its interim report. The Journal makes this report available in full in this issue. Attention should be called particularly to the emphasis on the use of government aid in the development of medical facilities where the need can be shown, government aid to medical education, medical research and the development of medical prepayment plans, and government assistance in certain situations in which the needs are clearly apparent for preventive medicine and for general health and planning toward a nationwide network of medical facilities.

"The report makes no specific recommendation in regard to health insurance but does point out that some form of group financing is desirable. It considers voluntary prepayment plans, compulsory sickness insurance, tax supported medical service or various combinations of these methods as techniques to be considered.

"Especially significant is the following paragraph from the report, which emphasizes state planning and control:

In order to permit local initiative and control, state programs should be drawn up by state health planning commissions in cooperation with local authorities. In drawing up state plans the commissions should consider the needs of all sections of the state, should include in the plan all suitable existing public and voluntary hospitals, and should plot the new construction as well as the expansion or replacement of existing facilities needed for adequate service. Before federal funds could be granted, however, overall state plans and individual projects should be reviewed and approved by the United States Public Health Service to make sure that they meet certain minimum standards of construction, operation and complete, coordinated service. There should be reasonable assurance that a new facility will have enough patients to justify its existence. In communities where sufficient income from fees of individual patients does not otherwise appear probable, provision for group prepayment plans or tax-supported services, or both, should be required.

"The report reaches us just as The Journal goes to press. The time is too short for detailed consideration of the various aspects of this report. The report, in general, would seem to be a more scientific, carefully considered document than has heretofore been available as a result of previous hearings in this field. The committee emphasizes that its findings are preliminary and that the subcommittee expects to continue its work with further hearings and with studies of the various aspects of the health problem, such as rural, industrial and school health, the health needs of veterans, medical research and medical education."

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MEDICAL ABSTRACTS

ACCIDENTAL TRAUMA AND TUMOR METASTASIS.

Benedict J. Toth. *Radiology*, XLII, 579, 1944.

Two cases are presented in which there appeared to be definite relationship between accidental trauma and the subsequent localization at the site of the trauma of metastasis from pre-existing malignant neoplasms.

In one case, the primary lesion was a bronchogenic carcinoma of the lung, and in the other a carcinoma of the stomach. The first patient suffered severe injuries to the right wrist and forearm, including a comminuted fracture of the radius an inch above the lower articular surface. This united, in good position, but progressively more severe pain developed in the wrist, with a soft-tissue swelling along the radial aspect, and marked osteoporosis.

Exuberant callus developed, and later the soft-tissue mass surrounded the fracture site. Except for periostitis and osteoporosis, no bony changes were demonstrable. At operation, a non-infiltrating circumscribed mass, loosely attached to the bone, was enucleated. It was found to be metastatic adenocarcinoma. A number of other metastatic nodules appeared in various locations. One, over the anterior aspect of the left leg, was believed by the patient to be the result of a slight bump several weeks earlier.

To help clarify the relationship between trauma and the development of the metastasis, an artificial trauma of the front of the right leg was produced by repeated blows with the wooden handle of a hammer. A hematoma was produced, but at postmortem examination, more than two months later, no evidence of tumor at this site was found.

The second patient suffered a compression fracture of the first lumbar vertebra, and abrasion of the scalp. He had a small palpable mass in the epigastrium. Progressive pain in the lower back and ribs developed. A destructive lesion of the eleventh rib was discovered. Numerous nodular tumors developed in the thoracic wall and elsewhere. Death occurred three months following this accident. At autopsy, a fungating carcinoma of the stomach was found, with many metastases affecting six ribs, both clavicles, the sternum, and the sixth and seventh thoracic vertebrae, but there was no evidence of tumor cells in the fractured first lumbar vertebra.

The seven postulates, set up by Segond and Thiem, Lubarsch, and Ewing as requirements to be fulfilled in the establishment of such causative relationship, were applied. It was found, in Case 1, that, while the metastatic tumor was located at the site of the fracture of the radius, it arose in the soft tissues, with gradual involvement of the bone over a large area, after the soft-tissue mass has reached considerable proportions. The same picture developed in the other metastases overlying bone.

In both cases, one or more of the seven postulates failed of fulfillment. These findings are in agreement with those of other investigators of the same problem. The author concludes that there is little evidence of any connection between trauma and the location of metastases from malignant tumor.—*E.D.M., M.D.*

HUMERO-RADIAL SYNOSTOSIS. E. Frankel. *The British Journal of Surgery*, XXXI, 242, 1944.

A review of the literature reveals only 22 reports of humero-radial synostosis. The author adds one case.

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INJECT 1 to 3 cc. Metrazol as a restorative in circulatory collapse, respiratory distress, deep anesthesia, and in morphine and barbiturate poisoning. In the emergencies of pneumonia and other over-whelming infections, and in congestive heart failure, give Metrazol, 1½ to 4½ grs., t. i. d.

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A male, aged 23, came under observation for severe uraemia from which he died. On antemortem examination, he showed bilateral humeroradial synostosis, with his elbows flexed at slightly less than a right angle. He was one of several children and four of them presented this same condition, although none of his ancestors had shown it. One of twins, but not the other, suffered from the same condition. Several of the children had abnormal patellae.

It seems certain that this was a hereditary condition. In embryos of fourteen and twenty-two millimeters, there is no joint space, but it is formed during the third intra-uterine month. In all these patients, the factor responsible for the deformities must have been active during the first three months of foetal life. Chronic renal disease was present in two of the seven children. Four of the children died before the early twenties; none has produced any children.—*E.D.M., M.D.*

KEY TO ABSTRACTERS

E.D.M., M.D. *Earl D. McBride, M.D.*

LOOK AT YERSELF!

When yer stummick's gittin' bigger
 An' yer breath's a commin' short
 An' yer hair's a gettin' thinner,
 That's the time you really ort
 To git yerself a bathroom scales
 An' every doggone morn
 Weigh yourself when you're still naked
 As the day that you was born.
 An' before you hide that carcass
 In the clothes you're goin' ta wear
 Give yerself "the old once over"
 In yer dresser mirror there.
 If you think yer jest as purty
 As you was when you was young
 Better get yer head examined
 'Cause it's tino that you begun
 To cut down in yer eatin'
 An' to spruce up in yer dress.
 If you don't, in jist a little while
 You'll be an awful mess
 With yer hair around yer collar
 An' yer feet a goin' flat,
 An' yer stummick saggin' lower.
 Look at you! Don't be like that.

J. Marion Read.

J.A.M.A.

When summer opens, I see how fast it matures, and fear it will be short; but after the heats of July and August, I am reconciled, like one who has had his swing, to the cool of autumn. So will it be with the coming of death.—Perry, Bliss. *The Heart of Emerson's Journals*, page 224. Boston and New York.

The salvation of America and of the human race depends on the next election, if we believe the newspapers. But so it was last year, and so it was the year before, and our fathers believed the same thing forty year ago. Perry, Bliss. *The Heart of Emerson's Journals*, page 240. Boston and New York.

There is not the slightest probability that the college will foster an eminent talent in any youth. If he refuse prayers and recitations, they will torment and traduce and expel him, though he were Newton or Dante.—Perry, Bliss. *The Heart of Emerson's Journals*, page 214. Boston and New York.

Dr. Kenneth M. Richter, Assistant Professor of Histology and Embryology, spoke at the Sigma Xi meeting, December 14. His subject was "Leucocytic Changes in Peripheral Blood."



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THROW OUT THE VITAMIN PILLS! ADVISES DOCTOR

One billion dollars is the annual economic loss to America from the common cold! Moreover, the average American is afflicted with one to five colds each year. These statistics are appalling in this war year, when the loss of man hours worked may affect the course of the war.

If the vitamins and vaccines you have used to prevent colds have not done their jobs, you have probably wondered why, considering the claims of the advertisements. The answer to your question and to your man-power problem is given by Noah D. Fabricant, M.D., in his new book, "The Common Cold," just published by Ziff-Davis Publishing Company.

In the ordinary reader's language, Dr. Fabricant has discussed the merits of sulfa drugs, penicillin, vitamins, nose drops, cold vaccines on the prevention and dosage of the common cold. The more homely questions of the effect of tobacco, alcohol, and Grandma's remedies have also been treated.

The tendency of the public to waste time and money on cold preventive fads is nothing new, the author pointed out. Not so long ago, mereurochrome was thought to be a cure for everything from blood poisoning to the common cold. Now it is recognized for its true worth, as an effective local antiseptic. Tomorrow the same may be true of today's fads.

A safe and sane treatment for the common cold based on proven scientific facts has also been outlined by the doctor. It is epitomized by the order, "Get into bed and stay there."

EDUCATION FOR THE PUBLIC ON WHOOPIING COUGH

With the peak of the 1,000,000 cases of whooping cough coming at this season, the current Upjohn educational message on pertussis is of special interest to pediatricians.

Appearing in full color pages in the *Saturday Evening Post*, *Life*, *Time* and other national magazines, the message will be seen by an estimated ten million readers, many of whom are unaware of the seriousness of pertussis and of the fact that by modern means the majority of cases can be prevented.

The message is illustrated by a painting of an appealing little girl by the distinguished artist Simka Simkhovitch. It asks the reader: "What if you could make almost sure she'd never get whooping cough?"

The message goes on to say: "In the first year of life whooping cough is so dangerous that it causes more deaths than diphtheria, scarlet fever, and measles combined. You want to spare your child the coughing and choking that put a strain on delicate chest and lungs. A million children used to catch this harrowing disease every year, but now vaccination can prevent it in more than 60 per cent of them. So have your child vaccinated while still a baby. Vaccination helps most children escape whooping cough entirely. Those who do contract it may have a milder case and not even whoop. I'd say this modern protection was worth a trial, wouldn't you?"

The message then urges mothers to take their children to their doctor for immunization or to call him promptly in case the child has already contracted whooping cough.

This message is one of a series on health education, sponsored by the Upjohn Company of Kalamazoo, Michigan. Other messages have discussed pneumonia, rheumatic fever, and blood plasma, always from the point of view of the doctor speaking humanly to his patients. Future subjects will be pregnancy, the menopause, and stomach ulcers.

EXPANSIONS AIM IN A MENNINGER REORGANIZATION*

*Treatment Available to More, Additional
Buildings Projected*

An expansion program entailing expenditures of more than 1¼ million dollars was tentatively outlined Thursday at a special meeting of stockholders of the Menninger Sanitarium corporation when they approved a resolution to dissolve the corporation as of next June 30 and to transfer its assets to the Menninger Foundation.

The transfer in assets, permitting a long-considered consolidation of activities in education, treatment and research, will involve buildings, equipment, grounds and other facilities of the clinic on West Sixth totalling \$325,000, of which \$200,000 will be a personal contribution of Drs. C. F. Karl and Will Menninger and their colleagues.

An earning capacity of \$70,000 to \$80,000 annually, along with the goodwill and prestige of an organization which has completed 25 successful years, will be additional donations.

Treatment of a larger number of patients, both adults and children, without regard to their financial status, will be a major aim of the foundation, for which a psychiatric hospital unit costing \$750,000 is contemplated.

Additional buildings trebling the capacity of the Southard school would cost \$250,000, and a psychomatic hospital unit for correlation of psychiatric and medical studies was projected at \$150,000. A fund of \$100,000 a year would permit low-cost treatment for patients with small incomes.

Estimates for postgraduate education, including training for young psychiatrists, physicians returning from military service, nurses, teachers and others, were placed at \$105,000; for research, \$149,000; for scholarships for promising children, \$30,000, and for publications, \$5,000.

An urgent need for psychiatrists and psychiatric treatment for mentally ill war veterans returning at the rate of 1,000 a day was reported in a brochure published in connection with the expansion of the Foundation. Emphasis was also placed on the necessity of making the same treatment available to a civilian population which has heretofore found it beyond its means.

An original partnership of fathers and sons now includes a personnel of almost 200 staffing a hospital on a 30-acre tract, the Southard school established in 1925 for the treatment of children, a library to further teaching and research and a department of psychology established by Prof. J. F. Brown, of the University of Kansas, and continued by Dr. David Rapaport.

Formally organized in 1941, the Foundation has as its members a group seeking to assist in the advancement of psychiatry. Its activities in its three years of existence have included a dozen research and educational projects, construction of a modern research building with laboratories, classrooms and offices and the receiving of contributions from four foundations and from individuals.

Development of shorter and more effective methods of psychotherapy has been a major research project to meet what was described as a critical situation. Teaching of psychiatry both as a specialty and as an adjunct to general practice and creation of a loan fund to assist young physicians in financing their psychiatric education are parts of the educational program.

Listed as officers of the foundation are: Chairman of the board, C. F. Menninger; president, Karl Menninger; vice presidents, W. C. Menninger, John R. Stone and P. E. Burtou; secretary, K. T. Toeplitz; assistant secretary, Mildred Law; treasurer, Robert P. Knight; assistant treasurer, M. W. Hoover; executive assistant, Jean Menninger.

*THE TOPEKA STATE JOURNAL, December 28, 1944.

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Atoka-Coal.....	C. D. Dale, Atoka	J. S. Fulton, Atoka	
Beckham.....	G. H. Stagner, Erick	O. C. Standifer, Elk City	Second Tuesday
Blaine.....	Virginia Cnrtin, Watonga	W. F. Griffin, Watonga	
Bryan.....	John T. Wharton, Durant	W. K. Haynie, Durant	Second Tuesday
Caddo.....	C. B. Sullivan, Carnegie	P. H. Anderson, Anadarko	
Canadian.....	P. F. Herod, El Reno	A. L. Johnson, El Reno	Subject to call
Carter.....	J. L. Cox, Ardmore	H. A. Higgins, Ardmore	
Cherokee.....	P. H. Medearis, Tahlequah	W. M. Wood, Tahlequah	First Tuesday
Choctaw.....		E. A. Johnson, Hugo	
Cleveland.....	F. T. Gastineau, Norman	Iva S. Merritt, Norman	Thursday nights
Comanche.....	George L. Berry, Lawton	Howard Angus, Lawton	
Cotton.....	A. B. Holstead, Temple	Mollie F. Seism, Walters	Third Friday
Craig.....	Lloyd H. McPike, Vinita	J. M. McMillan, Vinita	
Creek.....	C. R. McDonald, Mannford	Philip G. Joseph, Sapulpa	
Cnster.....	T. A. Boyd, Weatherford	W. H. Smith, Clinton	Third Thursday
Garfield.....	Jnlian Feild, Enid	John R. Walker, Enid	Fourth Thursday
Garvin.....	Marvin E. Robberson, Wynnewood	John R. Callaway, Pauls Valley	Wednesday before Third Thursday
Grady.....	Walter J. Baze, Chickasha	Roy E. Emannel, Chickasha	Third Thursday
Grant.....	I. V. Hardy, Medford		
Greer.....	R. W. Lewis, Granite	J. B. Hollis, Mangum	
Harmon.....	W. G. Husband, Hollis	R. H. Lynch, Hollis	First Wednesday
Haskell.....	William Carson, Keota	N. K. Williams, cCurtain	
Hughes.....	H. A. Ifowell, Holdenville	Imogene Mayfield, Holdenville	First Friday
Jackson.....	C. G. Spears, Altus	E. A. Abernethy, Altus	Last Monday
Jefferson.....	F. M. Edwards, Ringling		Second Monday
Kay.....	J. Holland Howe, Ponca City	G. H. Yeary, Newkirk	Second Thursday
Kingfisher.....	A. O. Meredith, Kingfisher	H. Violet Sturgeon, Hennessey	
Kiowa.....	J. William Finch, Hobart	William Bernell, Hobart	
LeFlore.....	Neeson Rolle, Poteau	Rush L. Wright, Poteau	
Lincoln.....	W. B. Davis, Stroud	Carl H. Bailey, Stroud	First Wednesday
Logan.....	William C. Miller, Gnthrie	J. L. LeHew, Jr., Guthrie	Last Tuesday
Marshall.....	J. L. Holland, Madill	J. F. York, Madill	
Maves.....	Ralph V. Smith, Pryor	Paul B. Cameron, Pryor	
McClain.....	W. C. McCndry, Sr., Pnrcell	W. C. McCndry, Jr., Purcell	
McCrtain.....	A. W. Clarkson, Valliant	N. L. Barker, Broken Bow	Fourth Tuesday
McIntosh.....	Lnster I. Jacobs, Hanna	Wm. A. Tolleson, Eufaula	First Thursday
Murray.....	P. V. Annadown, Sulphur	J. A. Wrenn, Sulphur	Second Tuesday
Muskogee-Sequoyah			
Wagoner.....	H. A. Scott, Muskogee	D. Evelyn Miller, Mnskogee	First Monday
Noble.....	D. F. Coldiron, Perry	Jess W. Driver, Perry	
Okfuskee.....	W. P. Jenkins, Okemah	M. L. Whitney, Okemah	Second Monday
Oklahoma.....	Gregory E. Stanbro, Okla. City	Ben H. Nicholson, Okla. City	Fourth Tuesday
Okmulgee.....	W. M. Haynes, Henryetta	J. C. Matheney, Okmulgee	Second Monday
Osage.....	C. R. Weirich, Pawhuska	George K. Hemphill, Pawhuska	Second Monday
Ottawa.....	P. J. Cnningham, Miami	L. P. Hetherington, Miami	Third Thursday
Pawnee.....	E. T. Robinson, Cleveland	R. L. Browning, Pawnee	
Payne.....	Haskell Smith, Stillwater	L. E. Silverthorn, Stillwater	Third Thursday
Pittsburg.....	P. T. Powell, McAlester	W. H. Kaeiser, McAlester	Third Friday
Pontotoc.....	A. R. Sugg, Ada	R. H. Mayes, Ada	First Wednesday
Pottawatomie.....	Chas. W. Haygood, Shawnee	Clinton Gallaher, Shawnee	First and Third Saturday
Pushmataha.....	John S. Lawson, Clayton	B. M. Huckabay, Antlers	
Rogers.....	R. C. Meloy, Claremore	Chas. L. Caldwell, Chelsea	First Monday
Seminole.....	J. T. Price, Seminole	Mack I. Shanholtz, Wewoka	Third Wednesday
Stephens.....	W. K. Walker, Marlow	W. E. Ivy, Duncan	
Texas.....	R. G. Obermiller, Texhoma	Morris Smith, Guymon	
Tillman.....	C. C. Allen, Frederick	O. G. Bacon, Frederick	
Tulsa.....	H. A. Ruprecht, Tulsa	E. O. Johnson, Tulsa	Second and Fourth Monday
Washington-Nowata.....	J. V. Athey, Bartlesville	S. A. Lang, Nowata	Second Wednesday
Washita.....	A. S. Neal, Cordell	James F. McMurry, Sentinel	
Woods.....	O. E. Templin, Alva	I. F. Stephenson, Alva	Last Tuesday
Woodward.....	Roy Newman, Shattuck	C. W. Tedrowe, Woodward	Odd Months
			Second Thursday

*(Serving in Armed Forces)

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Carcinoma of the Rectum*

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OKLAHOMA CITY, OKLAHOMA

The relief and hope that surgery has brought to those unfortunates, suffering from carcinoma of the rectum, have prompted the author to discuss the procedures which are employed on the service at the University Hospital in combating this disease. On this service, 31 cases were operated from 1940 to July 1943 and the results are reported in this discussion.

The most discouraging feature in this report is the advanced stage of the growth when first seen in the clinic. All patients are prepared for radical resection and the decision of what surgical procedure to carry out is made, after the abdomen is opened and the extent of the lesion is determined by palpation.

A simple colostomy is carried out on those in which the growth has involved the surrounding organs. The presence of metastasis in the liver or mesenteric glands does not contraindicate the resection of the lesion if it is amenable to surgical removal. We have been impressed by the improvement in general well-being, the increase in weight and freedom from pain following resection even when metastatic implants were present.

Recent authors have cited mortality rates of 20 per cent in simple colostomy. This is not surprising, but fortunately we have a much lower rate. The pain and discomfort and rapid decline of patients who receive only a colostomy have influenced us to attempt resection in every case if we think it is at all possible to remove the growth.

In those cases in which we have been unable to surgically remove the lesion, and have

carried out a colostomy only, we have given liberal exposures of x-ray and radium. We have found this is only a palliative procedure and in no way comparable to the surgical extirpation of the lesion.

In our series of 31 cases, two had a colostomy previous to resection. In these two cases the colostomy had been placed low over the symphysis. In both cases obstructive symptoms made it necessary to decompress the bowel before removal of the rectum.

This group consisted of 22 males and nine females. The age ranged from 35 to 78 years. The average age was 58. In this series there were three cases between 30 and 39 years; three, between 40 and 49; eleven, between 50 and 59; nine, between 60 and 69 and five between 70 and 79. These figures indicate the most susceptible age to be between 50 and 69.

The greatest number of days in the hospital was 103. The greatest number of days of hospitalization, before surgery, was 29 and the lowest number was two. Following surgery, the lowest number of days in the hospital was 20 and the greatest number was 100. The average pre-operative stay was 13 days and the average post-operative stay was 32 days.

Contact was lost with a number of these patients so that it was impossible to determine the average weight gain following surgery, however, in those with whom contact was maintained, some reported a gain as high as 25 pounds.

In 12 of these cases sulfanilamide was placed in the abdomen. About 50 per cent had sulfanilamide in the perineal portion of

*Delivered before the Annual State Meeting, Tuesday, April 26, 1944, in Tulsa.

the operation. Most of them had ten per cent tannic acid in alcohol applied to the perineal portion of the wound. This is both a nemostatic and a bacteriostatic agent. In one case a *B. coli* bacteriogen was placed in the abdomen. This case died and at autopsy, a pronounced peritoneal reaction was noted. Death occurred in six of the 31 cases making a mortality rate of 19.35 per cent. The causes of death were as follows: heart failure—1; evisceration and shock—1; plugging of the ureters by the sulfa drugs associated uremia—1; post-operative abdominal hemorrhage—1; peritonitis—2.

Sulfanilamide was not used in the abdomen in either of the two cases which developed a septic temperature and died from what appeared to be peritonitis. The case of evisceration was quite debilitated and healed very poorly although steel wire had been used as a stay suture in the abdomen in an effort to avoid evisceration. The case which died of uremia and plugging of the ureters by the sulfa drugs serves as a warning against this hazard in susceptible individuals. This case had an abundance of fluids both by mouth and by vein and only a moderate amount of sulfanilamide and sulfathiazole, nevertheless, the patient developed aneuria which was relieved by ureteral catheterization but died of uremia. One case developed an auricular fibrillation from which he did not recover. In the case which expired because of abdominal hemorrhage, evidently the ligature which was placed on the inferior mesenteric or superior hemorrhoidal arteries came untied or slipped. Experience has taught us that both of these arteries should be double ligated with plastigut.

Two cases had a MacBurney stab incision colostomy. I believe this is the least desirable position for a colostomy. It is difficult to control, protect or keep clean. Five of these cases had the bowel brought down through the perineum. One had the sphincter preserved and acting. The remaining cases had the functioning end of the bowel brought out through the upper half of the incision which I believe is the position of choice. Three of these cases had had previous surgery. One a fistulectomy, seven months previous, another a hemorrhoidectomy, eighteen months before, and the third a hemorrhoidectomy, twelve months before.

Two cases were operated on the regular surgical service. Dr. Raymond Murdoch and the author operated the other 29 of the series on the rectal service. While our mortality rate may be higher than that reported in some of the larger clinics, we believe that our results are quite in line with them. Many of our cases were quite advanced and when we operated them our only thought was to

relieve some of their symptoms and give them a few more months of life. Previously, Dr. Raymond Murdoch reported a series of resections which included both his private and clinic patients and the mortality rate was very much lower than in this series.

The symptoms and signs presented by these patients are recorded in the order of their importance: pain, bleeding; constipation—change in size and shape of stool; mucus discharge; diarrhea; weakness; loss of weight; mass in rectum. In some, these symptoms had been present 24 months. The shortest duration of symptoms was two months. The average before they were seen by us for surgery was twelve months.

The diagnosis of carcinoma of the rectum is not difficult. The classical symptoms of carcinoma of the rectum are listed above. These symptoms may develop gradually and considerable time may elapse between the appearance of the successive symptoms. On the other hand, the whole series may make their appearance within a period of two months. In any patient with rectal symptoms, carcinoma should be suspected, particularly if the patient is between the ages of 50 and 69. No physical examination is complete until the patient has had a digital rectal examination. No rectal examination is complete until the patient has had the lower bowel completely emptied by a soap suds enema and the interior of the sigmoid and rectum examined as far as possible with a proctoscope.

Any area presenting an abnormal appearance suggests the advisability of biopsy. Digitally a carcinoma of the rectum can be differentiated from an inflammatory condition, by the hard, woody feel. This feel might be compared to the rounded edge of a piece of sole leather. An inflammatory condition is more pliable and does not have this firm and woody feel. The x-ray findings in this condition are a roughening and a constriction of the lower sigmoid or the rectum.

Repeatedly the author has been impressed with the importance of thoroughly preparing these patients for surgery. We have found that the patients which we have put to bed and prepared before surgery have made a more rapid and satisfactory recovery. This preparation includes ten per cent glucose in saline by vein; blood transfusions, if the blood count is down; and daily hypodermic injections of liver extract and vitamin B. During this time we give repeated enemas and cleanse the bowel with small doses of epsom salts. The night before surgery these patients are given moderate doses of phenobarbital. This is repeated in the morning. Thirty minutes before surgery the patient is

given morphine and scopolamin. When they arrive at surgery they are in a sedated condition. This sedation is not carried to a point where it will interfere with the respiratory mechanism. We have been using spinal anesthesia. We believe that the most satisfactory drug is pontocaine. In a few cases it has been necessary to reinforce this spinal anesthesia with evipol, nitrous oxide, ether or cyclopropane.

An accurate blood pressure check is maintained by the anesthetist during the operation. After the patient is placed on the table an intravenous needle is placed in one of the veins of the foot and glucose is given during the course of the operation. We have tried all of the standard methods of preparing the abdomen for surgery but have returned to the old standby of iodine, phenol and borax.

We have found it most advisable to make a median left rectus incision and carry this incision from the upper limits of the bladder to above the umbilicus. The edges of the abdominal wall are protected by skin towels, or in some instances small especially prepared drapes, which are sometimes called salts. After the incision and draping is completed, the abdomen is explored for any pathology which may be present. It is advisable to first palpate the upper and lower surface of the liver to determine the presence or absence of metastasis, also one should determine if the gall bladder empties on pressure and should introduce the finger into the Foramen of Winslow. The stomach duodenum and transverse colon are then palpated. Next the cecum and the small intestines which lie on the right side of the abdomen are examined, and last of all, the small intestines on the left side of the abdomen, the descending colon, sigmoid and rectum. Any metastasis should be noted. The lesion of the intestine, should be palpated last. After this has been done, the gloved hand should not be again carried into the upper abdomen.

The patient is then put in a Trendelenburgh position. The sigmoid is brought out through the incision and by means of transillumination the inferior mesenteric, the sigmoidal and superior hemorrhoidal arteries are located. The optimum point of ligation of circulation above the growth is determined and the incision of the sigmoidal mesentery started at that point. In carrying out this dissection each artery or vein which is encountered should be crushed, divided and double ligated. This ligation should be done with No. 1 chromic or plastigut. The peritoneum should then be divided on both sides of the intestine close to the mesenteric attachments of the sigmoid. This division should be carried down as low as possible in the Cul de Sac. This separation of the

peritoneum is then carried around anterior to the intestine so that the two ends of the previous incision meet. Care must be exercised, especially when making this peritoneal incision on the left side, to avoid injuring the ureter which in many cases is directly beneath the operative field. Next the sigmoid and rectum are separated from their mesenteric attachments and all bleeders are double ligated. This separation and dissection is carried posterior down through the hollow of the sacrum until the dissenting finger palpates the coccyx, and is then carried forward on both sides of the intestine. At this point it is extremely important that the dissecting finger hug the bowel wall so that the separation is carried up in a plane which does not interfere with the ureter.

Next a small Pare clamp is placed transversely on the sigmoid at the original point of dissection and about one-half inch below this an Oschner is placed. Cautery is used to divide the sigmoid between these clamps and all the exposed tissues must be carefully protected from contamination or injury by material from the cautery. A small sterile sponge is now wrapped around the upper end of the bowel and this and the Pare clamp are temporarily laid to one side. An over and over suture is placed in the wall of the upper end of the lower bowel in such a manner that, when the Oschner clamp is taken off and the suture tightened, the end of the bowel invaginates itself. A large rubber penrose drain is then slipped over the end of the bowel and tied with heavy linen suture material, both above and below the point of division. This prepared portion of the lower bowel is tucked down into the posterior space in the pelvis previously prepared by dissection. The new floor of the pelvis is constructed by bringing together the cut edges of the peritoneum. These edges are brought together over the mesentery of the sigmoid and rectum up to the severed end.

Dr. Charles Mayo¹ advised that this suture not be interrupted at this point but be used to close the peritoneal edges of the incision, working downward from the point of colostomy. We have carried out a modification of this procedure by starting to close the peritoneum at the inferior end and including a slight amount of the mesentery of sigmoid at the upper end of the closure of the peritoneum. These are the only sutures employed in securing the colostomy in place, other than occasionally suturing a mesenteric tag to the fascia layer. This is important because if sutures are placed to include the wall of the gut and part of the incision and necrosis or trauma should cut these through, then small fistulous tracts are established which sometimes refuse to heal. The incision is now

closed above the protruding end of the gut. Extreme care must be exercised to preserve an abundant blood supply to the end of the gut which protrudes through the abdominal wall. The fascia should not be sutured so that the edges will bind the bowel. The sutures should be placed so that the finger can be introduced with ease on all sides of the bowel. Occasionally, to prevent any cutting or binding we have nicked the fascia on both sides of the bowel after it had been closed and sutured. In these cases we have found that it is advisable to place at least four grams of sulfanilamide in the abdomen before tight closure without drainage.

A dressing is applied to the abdominal part of the operation and the patient is rolled over on his left side. Care must be exercised not to disturb the needle which is in the vein of the foot. The right knee is flexed and the right foot brought up to the level of the left knee. The left leg is placed in an extended position. When the patient is ready for the dressing, the operative team step back and the circulating nurse and assistants put on the abdominal dressing and change the patient to the perineal position. The perineum is then scrubbed with soap and water. This area is prepared for surgery and the patient is draped. The sterile operative team again step in and take charge. The opening of the anus is closed by a heavy subcutaneous linen suture, the ends of which are allowed to remain about four inches long. An Oschner clamp which is placed on these suture ends is used as a retractor to put pressure on the lower end of the gut. A one inch incision is made anterior to the anus and transverse to the perineal body. The ends of this incision are joined by two incisions which meet at the tip of the coccyx. These three incisions form a small triangle with the anus in the center. The subcutaneous tissue and fascia posterior are divided by blunt dissection. The tip of the coccyx is located and the dissection carried to it and then upward, holding very close to its inner surface. Very soon ones finger enters the cavity which was created by the dissection of the gut previously carried down from above. This dissection is then carried forward on both sides of the rectum; care is exercised to stay close to the wall of the rectum in order to avoid the adjacent pelvic structures, and penetration of the lumen of the gut. When the gut is sufficiently freed, two fingers can be introduced up into the pelvic cavity and the rubber covered end of the rectum brought down through the perineal defect. Traction is then placed upon the rectum so that the muscles and fascia which are still intact may be clamped and ligated. At this point, in the male, care must be exercised not to injure the seminal vesicles, prostate or the urethra.

It is quite important during this part of the procedure to find and ligate all bleeders. The blood pressure usually drops to a low level during operation and a bleeder which is now oozing slightly will bleed profusely after the blood pressure has returned to normal. In most cases, at this point in the operation, we have applied ten per cent tannic acid in alcohol to the pelvic cavity. Sulfanilamide is liberally applied following the tannic acid. A subcutaneous stitch is started at the apex of the triangular incision and is carried forward so that the incision lacks only about one inch of being closed. We have used several types of suture material in closing. In our experience chromic catgut has proved the most satisfactory. The end of a one yard sponge is placed in a large rubber glove. This glove is slipped into the pelvic defect and the sponge is packed tightly into the glove so that pressure is exerted in the cavity. The operation is now complete and the patient is returned to bed.

Due to the debilitated condition of most of these patients and the magnitude of the operation, the after care is as important as any step in the procedure. When they leave the operating room most of them are in a mild state of shock. It is necessary to liberally administer blood transfusions and glucose in saline. These patients should have at least 3,500 cc of fluids by vein or subcutaneously in each 24 hours. The intake and output should be carefully watched, particularly if any of the sulfonamide drugs have been used pre or post-operatively. We have found it advisable to put in a nasal suction tube immediately following surgery and to keep this in place as long as it is needed.

We release and reset the Pare clamp on the functioning end of the gut about the third day, so that it includes only about one half of the entire bowel. Before this is done, however, the abdominal incision is covered with vaseline gauze. The use of this clamp is discontinued about the sixth day.

Charles Mayo¹ describes a procedure in which the gut is brought well out through the incision, the clamp on the functioning end removed and a rubber tube sewed into the end of the gut. This tube is then connected with a bottle beside the bed. Fredrich A. Coller and Henry K. Ranson² have described a procedure very much the same except that they bring the gut out through an inguinal incision and allow it to protrude about four inches. The protruding end has been previously invaginated and a catheter is implanted in the extreme end.

On the third day, part of the packing which was placed in the glove, in the perineal portion of the operation, is removed. This removal is continued each day so that

by the end of the seventh day the glove and the packing have been entirely removed. This is followed by irrigation of the wound with a weak solution of sulfanilamide in normal saline. Care must be exercised to make this perineal wound heal in such a manner so that there is no pocketing and so that it heals uniformly from the bottom out.

After our patient is up and moving about and the wound is closing by granulation, we institute our last stage in the procedure, which is the training of the bowel habit. We have found that the patient has better control of the colostomy, if in doing this operation, the left rectus muscle is split and the bowel is brought through the incision.

We advise our patients to avoid all articles of food which tend to give them loose stools. We suggest that by the use of an infant enema tip they take a small enema every morning. The patient soon establishes a habit of emptying the bowel at that time. There are several ways the patient may protect himself from soiling by untimely action of the bowel. One is by using pads over the colostomy held in place by an abdominal binder. A second method is the wearing of a rubber pouch sometimes called a colostomy pouch. Another very satisfactory arrangement is the use of a large flat metal ring. This ring has a device on both sides so that a rubber elastic band may be attached to it. This ring which

is about six inches in diameter is placed over the dressing which has been placed on the colostomy and the rubber elastic band is fastened securely around the abdomen. After these patients have been trained in the management of the bowel habit they are able to go about their daily routine the same as before the operation.

In closing, let me again insist that any patient who has the symptoms which have been previously referred to, should receive a complete physical examination. This examination is not complete until a digital rectal and an enema and proctoscopic examination have been made.

Richard B. Cottell of the Lahey Clinic³ made the statement that, of 331 patients seen at the Lahey Clinic with lesions of the colon, two thirds of these lesions could have been palpated digitally by rectal examination and viewed by sigmoidoscopic examination.

Let us get these patients to surgery while the lesion is small and well confined and metastasis has not taken place. Then and then only, will be get our five and ten year cures of carcinoma of the rectum.

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Otitis Media*

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Otitis Media may be divided into two general classes: Non-suppurative; Suppurative.

NON-SUPPURATIVE TYPE

The Non-suppurative type may be acute (acute tubal catarrh) or chronic catarrhal otitis media (adhesive process). Acute tubal catarrh is usually caused by infection in the nose or nasopharynx involving by contiguity

the eustachian tube. Improper blowing of the nose and swimming are sometimes responsible for transfer of the infection to the orifice of the Eustachian tube. The resultant swelling of the mucous membrane causes closure of the tube. This is followed by absorption of oxygen in the middle ear creating a vacuum. The tympanic membrane is retracted, the light reflex is usually absent and there is often redness of the malleus and shrapnells membrane. Moderate pain may be

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present, a feeling of fullness and noises are usually described by the patient. Vertigo may be present.

Treatment

Treatment consists primarily of elimination of contributing factors, such as adenoid growths, naso-pharyngitis or improper hygiene of the nose. Hot applications, auralgon, or phenol and glycerine will help to relieve the pain. Proper inflation of the Eustachian tube may relieve the condition immediately. This should be done gently and not at all if there is marked edema present.

Chronic Catarrhal

Chronic Catarrhal otitis media may result from recurrences of acute attacks, repeated attacks of naso-pharyngitis, nasal douching, and damp climate should be especially considered. Hypertrophic or atrophic changes in the mucosa of the middle ear are characteristic. The Eustachian orifice is likely to be edematous with ventilation of the middle ear becoming impaired. Later the secretions disappear, the mucous membrane of the middle ear becomes pale and thickened. Occasionally, fibrous bands bind down the ossicles and drum membrane to neighboring parts. Tinnitus is often the only symptom mentioned by the patient. Deafness for low tones, transitory aural vertigo are commonly described. The drum membrane is atrophied and calcified or may be thickened. The light reflex is usually absent. The Weber lateralizes to the affected ear. The Rinne test is negative. In most cases the Eustachian tube is blocked when tested by inflation, although slight improvement in hearing sometimes follows this procedure.

The Prognosis

The Prognosis is poor as to restoration of hearing after advanced changes have taken place. It is much more favorable when the changes are not permanent. Clearing up of diseases in the nose and naso-pharynx sometimes interrupts the process. The disease is self limited and while it may progress to some extent, deafness is not the rule.

SUPPURATIVE OTITIS MEDIA

Acute suppurative Otitis Media is usually attributed to some infection in the nose and throat, especially in the presence of acute infectious fevers, such as influenza, measles, scarlet fever and coryza. Injuries to the drum may cause an otitis media. Swimming especially with a cold will often bring on an attack.

Pathology

Changes in the middle ear and drum may occur within a few hours after the onset of an infection. There is intense congestion of

the mucous membrane lining the middle ear spaces, eustachian tube, antrum and mastoid cells. These spaces become involved by contiguity and the mucosa assumes a thickness many times the normal. The middle ear is filled with secretion which in the first stages may be serous or mucopurulent but later becomes purulent due to secondary infection from the canal. The type of secretion is related to the variety of bacterial invader. The Streptococcus usually produces a thin serous, and bloody discharge; the pneumococcus produces a rather thick discharge that does not drain readily. The most common bacteria are the hemolytic streptococcus, staphylococcus aureus and albus, diplococcus and bacillus mucosus capsulatus (pneumococcus type III). At first the organisms represent a monobacterial invasion, later contamination and cross infections produce a polybacterial picture.

Symptoms

The predominant symptom is pain in the ear, usually severe, which continues until the drum is opened either by paracentesis or spontaneous rupture. This is not always true in children. After an initial severe pain which lasts several hours there may be considerable though not complete relief even though the middle ear is filled with exudate. Fever is nearly always present and may be quite high, 103 to 105 degrees in small children. Convulsions are not rare. Hearing is always diminished in an acute suppuration of the middle ear, and in a recent article in the Archives of Otolaryngology was described as the best criterion for paracentesis. If hearing was good the author did not open the drum, if hearing was greatly diminished he did a paracentesis.

Treatment

The treatment is directed toward relief of pressure in the middle ear, this is best done by a well placed incision in the lower posterior quadrant. In addition to this general rest, alleviation of pain and chemotherapy will usually result in a rapid and complete cure. There is still a difference of opinion concerning the administration of the sulfonamides but it is my own personal belief that early incision of the tympanic membrane and immediate use of one of the sulfonamides for eight or ten doses offer the best chance for relief from pain, reduction in discharge and the preservation of hearing, also greatly diminishing the danger of complications. I have not had the opportunity to observe the effect of penicillin or gramacidin on this disease but from the existing reports we should see some startling results from the use of these chemicals.

CHRONIC SUPPURATIVE OTITIS MEDIA

There are cases in which there is merely a continued aural discharge with no tendency to abate, thus becoming chronic but without danger to life. There are others with a malodorous discharge, intermittent pain, dizziness and headache. This type of ear infection is a source of danger in that it may at any time involve the labyrinth, meninges or general circulation and terminate fatally.

One may ask why some cases clear up while others go on to chronicity. Measles, and scarlet fever not infrequently result in chronic ear infections. Perhaps this is because the resistance of the patient is already low. The anatomical development with recesses which do not drain well also favor continued infection.

Persistent naso-pharyngeal or eustachian tube infection may be responsible for continued drainage. The symptoms of a chronic otitis media include drainage from the ear, loss of hearing, and sometimes pain. The discharge may be thin and odorless, foul smelling, or it may be bloody in cases of granulations or polyps. Pain is usually not present but if it is probably indicates retention of pus, caries of the bone or intracranial invasion. Nausea, vertigo, tinnitus should be evaluated with the possibility of intracranial extension.

Treatment

The treatment is divided into two general types. The patient with a middle ear that drains after each cold through a small central perforation is usually benefited by clearing up infection in the nose, throat, and nasopharynx. Adenoids, a deviated septum or granulations around the eustachian orifice should be eliminated. Local treatment to the ear is of definite benefit in some cases. My own routine is to cleanse the ear with alcohol on a cotton applicator, carefully dry the ear then spray with sulfonilamide powder. This should be repeated every two to four days depending on the results. I am sure that the local application of sulfonilamide powder is of great benefit in some cases. On the other hand, a middle ear infection that produces foul smelling pus, some pain in the ear and forehead, occasional dizziness, especially if there is not a quick response to local treatment should have radical surgery of the middle ear and mastoid. The borderline cases with signs and symptoms between these two extremes require discrimination and judgment to determine the best course for both doctor and patient.

SUMMARY

With reference to symptoms and pathology, the concept of middle ear disease is substantially the same as it has been for the

past two decades but the treatment has undergone considerable transition and no doubt will continue to do so. I have not presented anything new but have attempted to summarize the salient features of otitis media.

DISCUSSION

J. C. MacDonald, M.D.

Dr. Watson has given us a concise picture of the different types of otitis media and their treatment. The disease is as it has always been, although the treatment as pointed out has changed considerably with the advent of chemotherapy.

In acute otitis media drops such as Auralgan or phenol in glycerine are used only in those cases which at first examination reveal only a slightly reddened ear drum and very little pain or temperature. The patient is seen and if the redness and fullness of the drum has increased, myringotomy is done.

I almost routinely use sulfadiazine in these patients, giving the full dose for three days and reducing the dose for two or three more days. No irrigations or antiseptics are used in the ear canal.

In patients with a purulent rhinitis or a severe nasopharyngitis, paradrine sulfathiazole suspension or 5 per cent sodium sulfathiazole in normal saline solution may be used with the hope that it may help clear up these infections.

In youngsters whose ears continue to discharge for a period of weeks, adenoidectomy often brings about a cure.

There is much difference of opinion as to the value of chemotherapy in acute otitis media and Dr. John R. Richardson of Boston, in an article on this subject, reports six sets of statistics by other writers with such varying results that it is rather bewildering. He reports 625 cases, only 20 cases of which received sulfanilamide therapy. These cases were followed from the time of incision of the ear drum until to complete healing. The incidence of mastoidectomy was 5.3 per cent, which compares favorably with those series reported by others in which sulfanilamide therapy was used. He also points out that; "due to the moral support of this drug therapy, the early or routine mastoid operation done in the first two weeks of the disease, an operation designed to prevent dread complications, has been largely abolished. This explanation may account for the seeming decrease in the incidence of mastoidectomy reported due to chemotherapy."

Dr. Lester L. Coleman of New York reports a series of cases in which mastoiditis and other complications occurred with practically no early symptoms due to masking effects of the sulfanilamides. It is therefore

important that all of these patients be followed until well.

There is no argument as to the value of chemotherapy in the complications of acute otitis media, such as meningitis and septi-cemia.

As to chronic suppurative otitis media there are, as Dr. Watson has stated, the non-dangerous and the dangerous types. Dr. Wallace Morrison of New York classifies the non-dangerous type as that with a central perforation of the ear drum of varying sizes and shapes, with or without granulation tissue or aural polypi, but at no point does the perforation involve the actual margin of the ear drum.

The dangerous and more common type presents "a perforation of variable size, form and location but which is marginal at some point or over some portion of its extent."

In the first type of case the inflammation remains limited to the mucous membrane of the middle ear and mastoid antrum.

In the other type with marginal perforation, an ingrowth of epithelium into the middle ear attic and mastoid antrum results. This continued growth of epithelial cells into a bony cavity causes pressure atrophy so that the dura, the lateral sinus or labyrinth may be uncovered and then with some acute infection some of these exposed structures may become involved.

In treating the chronic suppurative ear with central perforation I have never had much success with alcohol or alcohol-boric acid drops. Some writers contend they are definitely contraindicated in this condition. For years I have used Mucidin — 1 to 10 solution. This is an aqueous solution of potassium sulfocyanate and formaldehyde. This is applied to the middle ear after thorough cleaning, about twice a week. The results have been very satisfactory. In cases that do not respond to this treatment, sulfanilamide powder may be blown into the middle ear after careful cleansing or the patient may be given a prescription for 5 per cent sodium sulfathiazole in saline solution, which may be used daily after he has thoroughly dried the ear. These patients must be kept under observation so there will not be an accumulation of the crystals.

Another remedy widely used in this condition is Sulzberger's iodine and boric acid powder.

If granulation tissue or polypus are present they must be removed to allow free drainage of the middle ear and to allow the drugs being used to enter this cavity. Certainly any infections of the nose, sinuses and nasopharynx should be removed.

Treatment of the ear with the marginal type perforation is usually surgical. A radi-

cal mastoidectomy or some modification of it, depending on the pathology present, is necessary to bring about a cure.

Local treatment to cleanse the ear by irrigations of the middle ear cavity and attic of debris and cholesteatomatous material to allow better drainage, and the use of sulfanilamides locally, may control the infection for a long period of time.

How long to continue medical treatment depends much on the progress of the infection. When to operate and what kind of an operation to do depends much on the pathology present.

Medical School Notes

Dr. Albert Douglas Foster, Jr., has been appointed Professor of Anesthesiology, effective February 1, 1945. Dr. Foster received his A.B. degree from Harvard College in 1935, and his M.D. degree in 1939 from Harvard Medical School. Since January, 1944, he has served as an Assistant at the Rockefeller Institute for Medical Research. He is a member of the American Society of Anesthetists.

Mr. Henry Wade Hooper has been appointed Instructor in Histology and Embryology. He received his B.S. degree from the University of Oklahoma in 1926, his Ed.M. degree in 1932, and his M.S. degree from the University of Michigan in 1939.

Among the books recently received at the Medical School Library are the following: Archer, W. H.: *Life and Letters of Horace Wells, Discoverer of Anesthesia*, 1944. Chappell, G. S.: *Through the Alimentary Canal with Gun and Camera*, 1930. Harley, David: *Medico-legal Blood Group Determination*, 1944. Kelly, H. A.: *Walter Reed and Yellow Fever*, 1906. Koch, Robert: *Aetiology of Tuberculosis*, 1932. Wilmer, H. A.: *Huber the Tuber*, 1943. Zachariassen, W. H.: *Theory of X-ray Diffraction in Crystals*, 1945.

LET'S HELP OUR DOCTORS

Eufaula physicians are doing a marvelous job in keeping Eufaula healthy. They are overworked, some of them even are ill.

Though they are not in uniform, they are fighting a war that is tied up very closely with the armed battles overseas. They must combat the ravages of disease, and these duties sometimes require most of their night's rest.

Our hats are off to them.

One thing Eufaula might do to help these worthy gentlemen may sound as a trifle, but in reality it is not. Why not have our city council pass a resolution, reserving these Eufaula doctors a parking place on the streets of Eufaula, near their offices.

Oftimes have we seen one of the local medics endeavoring to reach his office, lose several moments searching for a parking place for his automobile. These minutes could have been more usefully utilized in administering to the sick.

It would not greatly inconvenience any of us to reserve these slots in our parking lanes, and it would mean a great deal to the "docs."—*The Eufaula Indian-Journal*, February 8, 1945.

SPECIAL ARTICLES

Such Is Life

LEWIS J. MOORMAN, M.D.
OKLAHOMA CITY, OKLAHOMA

Again lay reporting of things medical proves to be misleading. In the February 19 issue of *Life*, there is an interesting article on Psychosomatic Medicine. While this may be considered a very good piece of reporting, it is unfortunate that the average lay reader will be led to believe that psychosomatic medicine is a newly discovered art rather than a new term applied to a well known ancient practice now receiving special attention with the hope of offsetting the modern tendency to focus too intently upon the exact science at the expense of the art of medicine.

It seems safe to say that in a broad sense this practice was conceived by Socrates as he taught the youth of Athens in the Grove of Apollo; that it found fruition in the mind of Hippocrates who may have been the first to record its use and that it crops out in the writings of Plato and Aristotle and runs consecutively throughout the ages as shown by both medical and philosophical writings. Galen and Aretaeus in the second century A. D., display a knowledge of its value and reveal evidences of its application in their medical reports.

The following story testifies to Avicenna's familiarity with psychosomatic medicine in the Eleventh Century and his wisdom in its application¹:

"When he was at Jorgan Kabus, the sovereign of the country sent for him to visit his nephew, who was confined to his bed of a disorder that baffled all the physicians of that country. Avicenna, having felt the young man's pulse, and seen his urine, judged his illness to proceed from concealed love. He sent for the chief eunuch of the palace, and whilst he kept his finger on the patient's pulse, desired him to call over the names of the several apartments: observing great emotions in the sick man at the naming of one particular apartment, he made the eunuch name all the women in that apartment, and finding the patient's pulse to beat extremely high at the mention of one person, he no longer doubted but she was the object of his passion, and declared that his cure was only to be expected from the enjoyment of that lady."

Montaigne, 16th century, Apostle of nature and champion of common sense said, "'Tis not the soul, 'tis not a body that we are training up, but a man, and we ought not to divide him.'" In a discussion of the plague he said, "Your imagination all that while tormenting you at pleasure, and turning even your health itself into a fever." Considering the power of imagination he tells the story of:

"A woman fancying she had swallowed a piece of bread, cried out of an intolerable pain in her throat, where she thought she felt it stick; but an ingenious fellow that was brought to her, seeing no outward tumor nor alteration, supposing it only to be conceit taken at some crust of bread that had hurt her as it went down, caused her to vomit, and cunningly, unseen, threw a crooked pin into the basin, which the woman no sooner saw, but believing she had cast it up, she presently found herself eased of her pain."

Though Robert Burton's *Anatomy of Melancholy*², 17th Century, has received scant attention from the psychiatric standpoint, it deserves careful scrutiny in con-

nection with psychosomatic medicine. Under the title of "The Psychiatry of Robert Burton," Bergen Evans³ offers a discussion of this subject which the reader might well pursue. We quote briefly from Professor Evans:

"In his conception of the nature of the emotional basis of that distortion of the imagination which he felt to be the prime dynamic factor in neurosis he comes excitingly close to elaborating a theory of the unconscious mind. 'Perturbations and passions, which trouble the phantasy,' he says, in a passage which has already been quoted, but which is striking enough to be worth repeating, 'though they dwell between the confines of sense (feeling) and reason, yet they rather follow sense than reason, because they are drowned in corporeal organs of sense.'"

Coming down to modern medicine we mention only three among our master clinicians who practiced and taught psychosomatic medicine at the turn of the century, S. Weir Mitchell, William Osler and Francis Peabody.

In "Fat and Blood"⁴ Mitchell said, concerning the interdependence of mind and body, "Such moral medication belongs to the higher sphere of the doctor's duties, and if he means to cure his patient permanently, he cannot afford to neglect them."

Discussing medicine in the 19th Century, Osler⁵ wrote, "A third noteworthy feature in modern treatment has been a return to psychological methods of cure, in which faith in something is suggested to the patient. After all, faith is the great lever of life. . . . In one pan of the balance, put the pharmacopoeias of the world, all the editions from Dioscorides to the last issue of the United States Dispensatory; heap them on the scales as did Emipides his books in the celebrated contest in the 'Frogs,' in the other put the simple faith with which from the days of the Pharaohs until now the children of men have swallowed the mixtures these works describe, and the bulky tomes will kick the beam. . . . If a poor lass, paralyzed apparently, helpless, bed-ridden for years, comes to me, having worn out in mind, body and estate a devoted family; if she in a few weeks or less by faith in me, and faith alone, takes up her bed and walks, the saints of old could not have done more, St. Anne and many others can scarcely today do less."

In the "Doctor and Patient,"⁶ Peabody said:

"One might go much further, but these few illustrations will suffice to recall the infinite number of ways in which physiologic functions may be upset by emotional stimuli, and the manner in which the resulting disturbances of function manifest themselves as symptoms. These symptoms, although obviously not due to anatomic changes, may, nevertheless, be very disturbing and distressing, and there is nothing imaginary about them. Emotional vomiting is just as real as the vomiting due to pyloric obstruction, and so-called 'nervous headaches' may be as painful as if they were due to a brain tumor. Moreover, it must be remembered that symptoms based on functional disturbances may be present in a patient who has, at the same time, organic disease, and in such cases the determination of the causes of the different

symptoms may be an extremely difficult matter. Everyone accepts the relationship between the common functional symptoms and nervous reactions, for convincing evidence is to be found in the fact that under ordinary circumstances the symptoms disappear just as soon as the emotional cause has passed."

If time would permit, the physicians' knowledge of the power of mind over body could be traced throughout the centuries with the citation of many examples of its diagnostic and therapeutic significance. In spite of our desire for brevity, the following statement prompts further discussion.⁵

The author of Life's article on Psychosomatic Medicine says: "Psychiatrists have long contended that emotions (and deep subconscious conflicts as well) also can lead to incapacitating or even fatal physical illnesses. Although the medical profession as a whole never has been overly cordial to psychiatry, most progressive doctors today agree with this contention and it is within this area of agreement that the practice of psychosomatic medicine lately has developed."

In response to this erroneous statement which indicates that psychiatrists are gradually overcoming the medical profession's resistance to this so-called modern conception, we cite not only the above evidence of its acceptance from ancient times, but we call attention to the fact that one of the outstanding recent works on psychosomatic medicine by Weiss and English⁶ was largely inspired by Dr. C. L. Brown,* not a psychiatrist, but Professor of Medicine at Temple University. It should be noted that Weiss is Professor of Clinical Medicine and English, Professor of Psychiatry and that both were working under Dr. Brown's supervision. In addition we cite the very interesting work of the internist Julius Bauer⁷ in *Constitution and Disease. Under Psychosomatic Medicine*, Bauer says:

"The nervous system acts as one of the integrative systems of the individual constitution, insofar as its autonomic part regulates the function of practically all organs and tissues, including the endocrine glands. Whereas the regulation of bodily structures and functions by the endocrine system is chiefly of an enduring, so to speak tonic type, the nervous regulation serves for momentary, rapid adaptation of the body to various situations and stimuli. Since the endocrine activity is sub-

ject to nervous regulation, and the latter, in turn, is largely controlled by hormones, the most perfect system of mutual check and balance is secured in the constitution of an average person. The autonomic nervous system is also the moderator between mind and body, since it transmits emotions to the somatic sphere either directly or through the medication of the endocrine system, particularly the suprarenals."

Bauer, quoting Caughey⁸ presents the following definition of psychosomatic medicine, "That part of medicine which is concerned with an appraisal of both the emotional and physical mechanisms involved in the disease processes of the individual patient, with particular emphasis on the influence that these two factors exert on each other, and on the individual as a whole." He goes on to say, "To the medical practitioner there is nothing new about psychosomatic medicine."

Renewed interest in the art of medicine is badly needed because we have permitted cellular pathology, laboratory diagnosis including x-ray and other mechanical diagnostic and therapeutic agents to lead us away from the patient in our consideration of the disease.

Due credit must be accorded the psychiatrists for their part in pointing the way back. But every doctor knows that the interdependence of mind and body is of vital significance in all phases of medical endeavor, and that the solution of this problem which has become more acute because of medicine's own rapid development, should command the interest and cooperation of every member of the medical profession.

1. *Biographia Medica or Historical and Critical Memoirs of the Lives and Writings of the Most Eminent Medical Characters: Benjamin Hutchinson*, Vol. 1, p. 31. London, 1799.
 2. Burton, Robert: *The Anatomy of Melancholy*, Vol. 1. London, 1932.
 3. Evans, Bergen: *The Psychiatry of Robert Burton*. New York Columbia University Press, 1940.
 4. Peabody, Francis Weld: *Doctor and Patient*, pp. 42-43. The MacMillan Company, New York, 1930.
 5. Wickware, Francis Sill: *Psychosomatic Medicine*. Life, p. 51. Feb. 19, 1945.
 6. Weiss, Edward and English, O. Spurgeon: *Psychosomatic Medicine*. W. B. Saunders Company, 1943.
 7. Bauer, Julius: *Constitution and Disease*, Chapter V, p. 92. Grune and Stratton, New York, 1942.
 8. Caughey, J. L.: *Practitioner's Library of Medicine and Surgery*. Appleton-Century, Supplement, page 3, 1940.
- *Graduate of Oklahoma University School of Medicine, 1921.

United States Medicine In Transition

LEWIS J. MOORMAN, M.D.

OKLAHOMA CITY, OKLAHOMA

Under the above title the December, 1944 issue of *Fortune* devotes approximately 8,000 words to a discussion of medical service in the United States, ostensibly unbiased but in reality amounting to an astute argument for regimented medicine. The author has artfully employed well chosen factors in the unfair build-up which has been under way for the past twelve years. This undeserved propaganda has operated against free enterprise in general, but apparently medicine has been victimized because of the ready appeal inherent in the thought of sickness and suffering.

In the first paragraph it is admitted that: "Suffering due to lack of food — and latterly to lack of proper medical care — can produce community action in a way that other matters cannot . . . nobody gives a hoot whether or not night clubs or even movies are made cheaply available to all . . . but people who cannot find or pay for proper medical care are resentful, as are those who see the effects of such deprivations upon neighbors and, in the long run, upon the community."

Doctors will agree that the lack of adequate food

should stir the nation, not only because it is painful to go hungry, but because inadequate nutrition, is a major, direct and contributory factor in the cause of disease and disability. But we ask where is the movement to raise three and one-half billion dollars for the purpose of providing food, and knowledge concerning proper preparation and intelligent consumption of the same. A government, hell-bent on service to the people, might well undertake such a movement since it could be administered without robbing millions of good citizens and the medical profession of their rightful liberties. There is no reason why government food should not be good, but those who are well informed know that government (regimented) medicine is disastrous. As a domestic example we call attention to Louis I. Dublin's exposure of the Veterans' Administration's care of the tuberculous ex-service men of World War No. 1. As foreign examples we cite government controlled medicine in Germany and Great Britain.

Because of the fact that doctors have been too occupied with the task of applying advanced medical science

to the needs of the American people to adequately inform them of its importance, and because of the one-sided adverse build-up emanating from sources naturally accepted by the average citizens as authoritative, and finally because of emotional trends occasioned by mass war psychology, many of the American people are ready for a change. Again the oft repeated saying, "The American people are down on what they are not up on" is apropos. Figures from surveys are quoted to show the unrest and the inclination toward what the author calls a "change in structure and economics." To the honest doctor who knows he has helped give the American people the best medical service ever given any nation in the history of the world, it seems a dirty trick to make surveys and quote results on the heels of the twelve year build-up, and after approximately one-third of the American doctors have left their patrons at home and volunteered for military service in order to carry this advanced medical and surgical science to our sons and daughters at the front. Those who doubt the efficacy of American medicine at war should study the recorded facts. Those who stand ready to say, "Is not this regimented medicine?" should remember that the great bulk of it is voluntarily contributed by civilian doctors temporarily in uniform, because the spirit of service constrains them.

In answer to the statement that "among the increasing numbers of laymen, influential citizens, and even doctors who have long recognized the medico-social problem," let us call attention to the fact that doctors have always been among the first to recognize such problems and among the few who have had the patience to deal with them effectively. It is of interest to note that Ibsen originally hoped to reform the world through his plays, but finding this impossible he began to use doctors as characters in his plays because they were hopeful menders and not hopeless reformers. They patched the broken human body without regard to social, economic or moral issues. This leads to the question of medical freedom and the necessity of the present patient-doctor-God relationship. This is much more essential than the people at large realize. If there is not an awakening, the public may learn this when it is too late.

In answer to the statement that "the war staved off the conflict over medicine. The armed forces absorbed one-third of all the active United States doctors. The civilian medical crisis — while it became so serious as to overshadow the peacetime medical problem — also became tolerable because viewed as a war phenomenon," we may say that this argument falls flat when analyzed in line with the facts. Losing one-third of the doctors to the Military Service could not have eased the unrest at home through tolerance because of this "war phenomenon." War does not make people more tolerant of flagrant evils at home. A flogging committee would be more probable. As one who works daily on the home front, the author knows that the reception he receives is an expression of genuine appreciation and not just war tolerance. He knows that the people are partially aware of the fact that doctors still have sufficient personal liberty to spread the available medical service throughout the community, by working overtime for rich and for poor, for pay or for nothing, as he chooses, and they appreciate his willingness to do so. Not even the court condemned, so-called American Medical Association Trust dares to impose rules and regulations in this patient-doctor-God relationship. Long before there was an American Medical Association, the Hippocratic Oath placed the patients' interest first and no doctor worthy of the profession would have it otherwise. The author has been a member of the American Medical Association for more than four decades without receiving mandates or requesting instructions. He would not continue his membership if he could not trust this organization to forward scientific progress in behalf of the people without interference with the personal relations between doctor and patient. If civilian doctors were not regimented on an eight hour schedule instead of working twelve to eighteen hours, many people who now have good care

would be clamoring for a doctor and those favored by the bureaucrats would be missing the intimate personal relationship so essential in good medicine. Only the doctors free initiative has made possible the service spread which has held high the health level during this great crisis.

Again quoting, we find the following: "And, while still opposed to change, the American Medical Association has lately been weakened in its fight. In 1939 the United States Supreme Court recognized that medicine is not only a profession but also a trade. The consumers — real or potential — of its services are all the people of the country. And the court dealt medical stand-patters a blow when, in effect, it instructed consumers that they have a right to examine the non-professional aspects of medicine just as they may examine other trades. Said the court: "The licensed monopolies which professions enjoy constitute, in themselves, severe restraints upon competition. . . . There is sufficient historical evidence of professional inadequacy to justify occasional popular protests. The better educated laity of today questions the adequacy of present-day medicine." Doctors know that it is within the Supreme Court's sphere to decide whether medicine is a profession or a trade. Considering the courts' decision they feel that the evidence presented was insufficient or the decision unfair. The court may have thought it a stroke of generosity to declare medicine both a profession and a trade. It is true that a court decision can make trouble, but it cannot make a trade of the medical profession. The spirit of American medicine was molded by voluntary rules of right and wrong growing out of the "primal sympathy of man for man" and not by court decisions.

Doctors may justly question the court's right to rule on the quality of medical service. The members of the court were not qualified by education or experience to pass upon the question of professional efficiency. It is doubtful if a single member of the Court could have qualified for admission to any accredited medical school in the United States. If any of the judges should want to enter a *trade* formerly requiring eight to twelve years of hard study, the government's accelerated plan of medical education may open the doors. The standards voluntarily set by the doctors are too high for the judges.

The following paragraph presented without qualifications, indeed, sound ominous to the average layman: "In the first place, the state of American health is nothing to cheer about. The people of the United States lose about 1,500,000 man-years of work annually through sickness. From 30 to 50 per cent more mothers (and about 50 per cent more infants in the first month) die than would die if all got good medical care. With more surgery and radiation, 30,000 cancer victims a year could be saved. Of 13 million men examined for the draft, 20 per cent were rejected for medical reasons; this figure takes no account of rejections by reason of such special causes as mental deficiency, mental diseases, or dental troubles. In short, too few Americans are getting the medical care that they need and that the community needs for them."

This is a sweeping statement but it does not sweep clean. Giving the first sentence in the above paragraph a paradoxical turn, a prominent New Dealer said, shortly before the War, "we have in the United States today two serious problems — one is the youth group and the other is the old-age group." The gentleman, who is an ardent advocate of so-called better health service through government control seemed unaware of the fact that medicine in the United States had been good enough to produce both problems. Apparently he did not know that added saving of life in infancy and the fostering of health in childhood and adolescence had produced a vigorous youth group clamoring for opportunity before the War solved the problem. He seemed equally unaware of the fact that increased longevity, resulting from better medical care, had created a mounting old-age group, demanding merciful consideration.

Now that we are apprised of the fact that the people

lose so many "man years" annually through sickness, why not let the people know that much of this loss is attributable to indifference and to their lack of knowledge, and the government's failure to supply instruction, direction, adequate food, housing and a healthful environment. The medical profession can make available to the government the knowledge needed for the solution of these problems.

Many people in the United States believe in Christian Science or other healing fads, including many medical "isms" the members of which are permitted to operate under the name of *Doctor* without government interference. The people who follow these cults purposely avoid the regular practitioner of medicine when they are sick. In addition there are many more who never see a doctor until they feel sick and it should be known that unfortunately many of the most dangerous diseases progress to a serious degree before they drive the patient to the doctor.

The statement with reference to Cancer is misleading. More surgery and radiation are available and it is possible that 30,000 lives could be saved if the people would heed the doctor's advice and present themselves for diagnosis and treatment as soon as symptoms arise. As early as 1913 a group of doctors organized an educational movement designed to warn the people of danger and to urge early diagnosis and treatment. Out of this movement came the American Society for the Control of Cancer, now the American Cancer Society. This movement was initiated by doctors and has remained under the direction of the medical profession. In spite of this movement 150,000 people die of cancer annually because of ignorance or willful neglect. More knowledge and more action on the part of the people would enable the doctors through surgery and radiation now available to save more than 30,000 lives. A Federal educational campaign to supplement the doctors movement, American Cancer Society, actively supplemented by Womens Clubs, would be welcomed by the medical profession. Certainly doctors should have credit for what they have done rather than blame for what others have failed to do.

Finally, the people should know that many disabling conditions have an hereditary background and that their parents and grandparents must share the blame. Oliver Wendell Holmes insisted on looking back through many generations. In truth, we begin life with marked individual variations, physically and mentally. As soon as we pass the threshold of the womb we are headed for the tomb. Through disease and other environmental insults we begin to die as soon as we are born. Yet our politicians and our would-be social reformers expect us to arrive at the draft center in pristine perfection. If human beings were frozen at birth, placed in cold storage and thawed out at the draft age, they might present only their hereditary defects, but the War would be lost.

It is not fair to blame medicine for all diseases and physical defects discovered at induction centers every time the excitement of War opens the eyes of the government and arouses the people. If the government would remain awake and alert, it might find many ways to help medicine to a higher degree of perfection as a free enterprise.

If the government, already looking upon medicine at a mere trade, institutes a regimented medical service, the findings at the induction centers, in wars to come, will be revealing, if not embarrassing. It is now time for the people of the United States to know that their physical well being and even their daily existence depend upon medical knowledge freely and skillfully applied throughout the land; that this knowledge has reached its present high level through a process of evolution covering a period of 2,500 years and that the motivating spirit has been that of free enterprise with tireless, sleepless periods of hard work and individual investigation. Progress in medical science has never clicked with the clock; has never followed a regimented regime or bowed to a bureaucratic boss.

Since the article in the December *Fortune* makes the people appear unduly naive because of their trust in the "solo practitioner" it is only fair to say a word in defense of the family doctor, so artfully damned by faint praise. The great majority of the people in this country, capable of assuming responsibility, in private or public life, were brought into the world by "solo practitioners." In fact, their mothers, if still living, would agree with the beloved Will Rogers that being born is a private affair and they would not want the "grop" present, neither would they welcome a government agent.

We wonder if the author of the *Fortune* article happens to know that the kindly face and the sympathetic features pictured in the reproduction of Sir Luke Fields' "The Doctor" which he dubs the "solo practitioner" represents Dr. James Clark, later Sir James, of London, who attended John Keats when he was dying of tuberculosis far from home in the Piazza di Spagna, Rome. Even though his disease had passed beyond control we imagine it meant much to Keats to have the care and comfort of this "solo practitioner."

The homage which Shelly, in his "Adonais," showered upon his poet friend Keats, might well replace the cheap designation of "solo practitioner" placed above Luke Fields' famous painting and it would serve as a fitting tribute to every family doctor who has given his life for his friends.

It is only fair to say that editors and publishers who print the unfavorable propaganda about American medicine might follow a different course if they possessed sufficient knowledge to give them a genuine understanding of the medical profession and its mission in the United States. The fundamental facts concerning medicine and its achievements should be placed before the public. Inform the people and they will instruct the lawmakers. Those who live by the vote will listen to the voters. We need more medical knowledge in government and less government meddling in medicine.

The so-called society security of the Bismarckian Golden Age paved the way for Der Fuehrer. The proposed Wagnerian Golden Age should put Bismarck to shame and bring swift catastrophic retribution to all who love liberty.

MEDICAL AND SURGICAL RELIEF COMMITTEE REPORTS

Mr. Arthur Kunsinger, treasurer of the Medical and Surgical Relief Committee, today announced that for the six month period ending December 31, 1944, the Committee's donations to 21 countries including the United States, amounted to \$43,669.87.

The territory covered by the Medical and Surgical Relief Committee has increased as the number of liberated countries has increased, and contributions now reach France and Italy. United States tops the list of beneficiaries with \$16,386.48 worth of medical, surgical and dental supplies of which the U. S. Navy got \$3,542.13, the U. S. Army \$1,025.40, and various civilian hospitals and welfare agencies the balance of \$11,818.95. The greatest number of shipments for this period went to China and India, while the most valuable single contribution amounting to \$4,951.76 went to L'Entre Aide Francaise for the relief of French children.

The Medical and Surgical Relief Committee is distinguished by its adherence to two principles: 1. No authentic appeal is ever turned down, and 2. Medical aid is the only form in which aid is given. Contributions of medical, surgical and dental supplies and instruments will soon reach the \$700,000 mark. The exact figure to date is \$690,715.60.



A child's second birthday does not confer a magical protection against rickets, as has well been demonstrated by a recent study¹ at Johns Hopkins Hospital in which almost fifty per cent of the children between the ages of 2 and 14, who died from various causes, were shown to have evidence of rickets.

Protection "as long as growth persists" can be readily achieved with dependable, potent, Upjohn vitamin preparations, available in forms that meet the varying needs of infancy, childhood, and early adolescence.

1. Am. J. Dis. Child. 66:1 (July) 1943.



Upjohn Vitamins

DO MORE THAN BEFORE—KEEP ON BUYING WAR BONDS

THE PRESIDENT'S PAGE

This will be the first year in the history of the State Medical Association when the annual meeting will not be held. As has already been indicated, our application has been denied by the Office of Defense Transportation. In order to stay within the rule we must limit the number of delegates gathered together to transact the business of the Association to not more than 49. Your officers and the Council are eager to cooperate in any way within our power to aid in bringing about a speedy conclusion of the war. No sacrifice is too great, or no inconvenience too disconcerting if it will help in obtaining this objective. At the same time, however, the work of the Association must go on. New officers have to be elected and installed, financial matters adjusted, committees appointed, and many other routine items of business transacted in order to preserve the function of the organization.

We fully realize how difficult it will be for a small group, actually less than one-third the total number of delegates, to discharge their responsibility to the satisfaction of all. With this in mind we ask you to contact your delegates at once and call to their attention any matter which you believe should receive attention. The allocated number of delegates from each Councilor District has been submitted for approval to each District through its Councilor and as soon as the list is complete, it will be published in the Journal.

The writer feels that in connection with the election of officers, the House of Delegates as organized this year probably should constitute a nominating committee which, in turn, would submit the proposed nominees to all the Delegates for final vote. By this means a more democratic election will result and the gentlemen chosen will feel better about it.

Considerable progress has been made this year in welding the Association together as a powerful influence in matters which affect the health and welfare of the people of the State of Oklahoma. While victory is in sight, the battle is not yet won. We must not give up. There is much to be done and it will require hard work on the part of each and every one of us before the goal is finally reached.



President.

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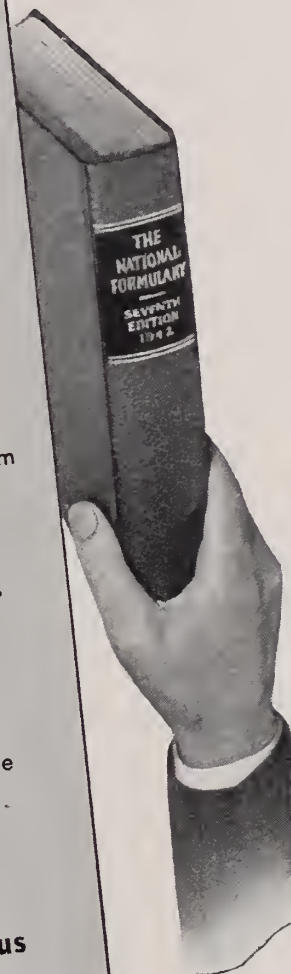
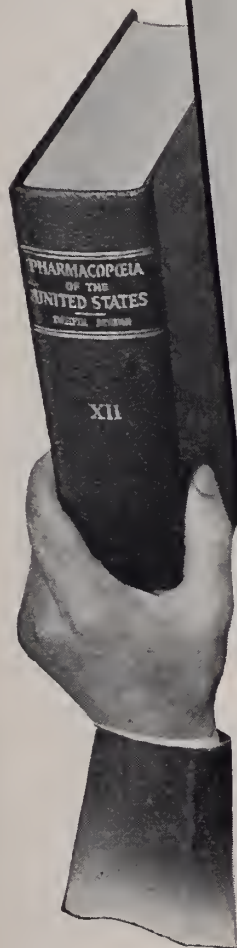
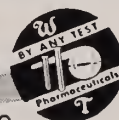
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EDITORIALS

A PATIENT SPEAKS OUT

Repeatedly these columns have been devoted to a discussion of regimented medicine from the doctors viewpoint. We are glad to present the patient's reaction to government medicine in operation. No doubt, many intelligent patients will rue the day they gave their liberty away, if they face the red-tape-worms who administer regimented practice.

"You asked me for an X-ray in January. An X-ray is on its way. However, due to governmental red tape, there are definite complications.

"You see, I thought I would take advantage of the Coast Guard's medical care for C. G. wives. Harold made arrangements for me to have an X-ray taken and sent to you to be kept in your file of X-rays for me. Yesterday afternoon I went to receive this 'benefit.'

"I was bogged down in the Baby Department for 45 minutes while Harold dashed around frantically trying to repair the damage done by a clerk who had mislaid my card. I was finally escorted to the X-ray room,

where the X-ray was taken by a rabbitly looking little man whose manner did not inspire confidence. After all of that, I was informed that you could not keep the X-ray, but would merely be permitted to look at it. I knew (or thought, anyhow) that that wouldn't be of much use to you, as you'd need the X-ray for future comparisons.

"I went to see the Executive officer. He was out but I was firmly told by his very determined secretary that they had to have it on file. That it was for my own protection, as maybe my doctor would say I'd never had a spot on my lungs. Or something equally as asinine.

"If you want me to have another X-ray taken, I'll be glad to. Anything would be inexpensive, compared to what I've been through on this one. Heaven protect us from Socialized Medicine!"

In justification of the patient's critical position, it is only fair to say that the Roentgen Ray was found to be of no diagnostic value because of what appeared to be over-exposure.

THE SIGNAL NODE IN CANCER

In the February, 1944 Archives of Surgery, Viacava and Pack¹ point out the importance of the deep inferior cervical lymph nodes in connection with cancer. While cancer of the head and neck may involve these nodes, we are primarily interested in their participation, the course of intrathoracic and intra-abdominal cancers.

The authors are not pointing to a newly observed phenomenon but urging alertness in its apprehension. The close connection of these nodes with the great lymphatic collecting vessels, the thoracic duct of the left and the lymphatic vein on the right, exposes them to the pathologically reversed lymph flow, thus leading to a retrograde invasion of the supraclavicular nodes from thoracic and abdominal cancers.

Unfortunately, metastatic cancer in these nodes warrants a poor prognosis but discovery at least offers a clue of diagnosis. Of 4,365 cases studied, 122 exhibited metastasis to the signal node in cases suffering from thoracic or abdominal cancer. It was the first sign of cancer in 41 cases. In carcinoma of the lung, it was observed in 13.2 per cent; in carcinoma of the pancreas 8.1 per cent, esophagus 7.1 per cent, ovary 6.1 per cent, testis 4.8 per cent, stomach 2.6 per cent. Intrathoracic new growths affect the two sides almost equally while intra-abdominal carcinomata usually affects the left node. The apparent increase in carcinoma of the lung adds significance to this discussion. But it is to be hoped that a wise use of accumulated knowledge and improved diagnostic facilities may anticipate the signal node and offer the victims a much earlier diagnosis and a better chance at pneumonectomy or the palliative use of x-ray.

1. Viacava, E. and Pack, G.: Significance of a Supraclavicular Signal Node in Patients with Abdominal and Thoracic Cancer. Archives of Surgery. Vol. 48, page 109. February, 1944.

STOMATITIS

The attention of the public has been drawn by the press to a virus infection of infants which proved fatal in five instances. That peculiar lesion of the mucous membrane of the mouth of small infants usually with digestive disturbance is well known. The nature of such lesions has not been known.

Dodd, Johnston and Buddingh², in 1938, proved the presence of the herpes simplex virus in the lesions of what they choose to call "herpetic stomatitis." The condition is one which commonly occurs in children between one and three years and is characterized by fever and peevishness followed shortly by the appearance of red, swollen, bleed-

ing gums and ulcers on the buccal mucosa and often on the tongue and inside the lip. Spirochetes and fusiform bacilli were almost always absent from the localized lesions of the mucous membrane but were quite commonly found in smears taken from the swollen gums. Intranuclear inclusions characteristic of herpes were demonstrated in the corneal epithelium of rabbits infected by material from these lesions. Specific immunity to herpes virus was established in the rabbits within two to four weeks after inoculation. They concluded that the type of stomatitis described is a definite clinical entity with the virus of herpes simplex as the causative agent.

In 1944 Buddingh and Dodd² described another type of stomatitis occurring in infants which also appears to be due to a filterable virus but not the virus of herpes. The majority of cases were observed in infants under six months of age. At one time 16 of 30 infants in the newborn nursery developed the disease.

The infants have little or no fever but are fretful. The tip, anterior margin and under surface of the tongue are fiery red. Later the mucous membrane of the tongue desquamates, leaving a raw surface which bleeds readily. Many of the infants suffer from a moderate diarrhoea. The stools are frequent, contain large quantities of mucus and sometimes flecks of bright red blood. The disease, in most instances, lasts from three to ten days but apparent recovery is often followed by one or more relapses so that it may be at least two months before the child is entirely well.

The disease is highly contagious and may be transmitted by adults who harbor the virus. Three of the four nurses in the nursery at the time of the epidemic carried the virus and one of them developed the disease and carried it home to her two children, ages six and eight.

The virus was found in the lesions of the mouth and in the stools. Rabbits which were inoculated were refractive to re-infection but when subsequently inoculated with the virus of herpes developed a typical herpetic keratitis.

A description of the disease in adults is offered by one of the investigators (G.J.B.) who accidentally received a small amount of the infectious material directly into the mouth. On the third day moderate malaise and headache developed. Later in the day the tip and anterior edges of the tongue became painful and felt as if they had been scalded. The mucous membrane of the lips became markedly swollen and red. The tip, anterior edges and undersurface of the

tongue were fiery red. No fever developed. The following day there was widespread desquamation of the epithelium of the mucosa of the lips. The subjective symptoms were much improved. By the fourth day after onset of symptoms the mouth was again normal. No diarrhoea developed.

Inasmuch as these virus diseases are self-limited and resist any treatment so far tried, the haphazard diagnoses of aphthous stomatitis, Vincent's and thrush have done no particular harm. It is gratifying, however, to know definitely with what one is dealing. Apart from the clinical significance of the papers they are well worth reading for the work was beautifully done and comes as near fulfilling Koch's postulates as it was possible to do.

1. Dodd, K., Johnston, L. M., and Buddingh, G. J.: *J. Pediat.* 12:95. 1938.

2. Buddingh, G. J., Dodd, K.: *J. Pediat.* 25:105. 1944

APPROPRIATE REMARKS ABOUT APPROPRIATIONS

Recently the writer had the privilege of attending a session of the Appropriations Committee of the State Legislature. This Committee is made up of members from the House of Representatives and the Senate. The session attended was devoted to a study of the budgets of the Medical School and the University Hospitals for the next biennium.

The most impressive and striking feature of the evening was the general attitude which the legislators demonstrated toward the requests for funds. The questions which were asked, and practically every member of the committee in attendance asked one or more questions, demonstrated a thoughtful and intelligent approach to a proper solution. No antagonism was even hinted — the prevailing attitude was to determine the reasonable needs of the various institutions and to provide for such needs.

The Chairman of the Committee, while giving adequate opportunity for questioning, was still able to prevent any time-consuming, futile, unnecessary, unenlightening discussions. Apparently, he thoroughly understood the job he had to do and knew just how to accomplish it.

One naturally asks oneself the reason or reasons for such an unusual situation. In this instance as in so many similar ones, the answer is multiple. Undoubtedly, the general make-up of the Appropriations Committee offers one good reason. Another is that those in attendance representing these institutions from the Dean and Superintendent of the Hospitals on down were well prepared to present a true picture of the requirements

and to answer all questions asked. It appeared as if most of the questions had been anticipated.

Although it is important that the Medical School and the University Hospitals have adequate funds such is not of single importance. It is of equal importance that the legislators who have a responsibility to their constituents and the doctors who have a responsibility to the indigent sick of the state can in a spirit of superb and laudable friendliness work together for the greater good of all. Both groups are to be congratulated.

ALUMINUM IN MEDICINE AND INDUSTRY

One of the most interesting scientific investigations now under way in the allied fields of medicine and industry is the antagonistic relationship between metallic aluminum and silicon dioxide (free silica) when they meet in the human organism. The Workmens Compensation Act in Ontario, 1926, making silicosis a compensable disease, caused the late Sir Frederick Banting who had long been interested in silicosis, to suggest an experimental investigation. This suggestion was carried out at The McIntyre-Porcupine Mines, Ltd., Ontario, in November, 1932. A preliminary report was published by Denny, Robson and Irwin¹ in 1937. A second report by the same authors² appeared in 1939.

Commenting on this work, Crombie, Blaisdell and MacPherson³ present the following pertinent facts:

"Accepting the theory that silica exerts its injurious effect upon animal tissue through a slow transformation into silicic acid in the presence of body fluids, these authors assumed that if the solubility of the silicious material retained in the lung could be sufficiently reduced, the usual fibrotic response would be modified or would not occur. A search was therefore undertaken for some non-toxic compound that would fulfill this purpose. After investigating many substances, Denny and Robson discovered in 1936 that the presence of small amounts of aluminum powder almost completely inhibited the solubility of silicious material *in vitro*. An intensive study of the mechanism involved later showed that the reduction in solubility was due chiefly to a coating of the silica particle with a thin film of a gelatinous hydrated alumina which, on drying, formed the crystalline alpha aluminum monohydrate boehmite ($\text{Al}_2\text{O}_3 \cdot \text{H}_2\text{O}$). The presence of this adsorbed layer on the surface of the quartz was indicated by staining it with aurin (Ammonium salt of aurin tricarboxylic acid) and proved by Germer and Storks

by means of electrom diffraction patterns.

"Inhalation experiments with animals were at once begun, using pure quartz dust with and without aluminum powder. (See original communications.) These observers showed that while typical silicosis was produced in about 5 months in the control animals receiving silica dust alone, the addition of 1 per cent aluminum powder to inhaled silica dust completely prevented the occurrence of silicosis, even after exposure had been prolonged up to 22 months. It was further shown that the inhaled aluminum powder should be of a particle size below five microns and that it might be inhaled independently of the silica dust. . . . The inhalation of large quantities of aluminum powder for prolonged periods produced no harmful effects in the experimental animals."

With these conclusive facts in hand and the harmlessness of aluminum dust apparently well established, Banting, Denny and associates, as early as 1939, decided to apply this knowledge to the problem of human silicosis. Because silicosis, under ordinary conditions, develops so slowly, it was deemed advisable to try the inhalation of metallic aluminum on established cases of human silicosis for the determination of its therapeutic effects. It was assumed that if it possessed therapeutic virtues, it could be counted on as a prophylactic agent.

In order that this work might be independent of the original investigations carried on by Denny, Robson and Irwin¹ the task was assigned to Crombie, Blaisdell and MacPherson³. In preparation for this important bit of investigation, the authors visited the Pittsburgh plant of the Aluminum Company of America where aluminum sheets were being pounded into dust for processing into paint, ink, etc. Here they studied serial x-rays, extending over a three year period, of 125 workmen who had been exposed to this dust for periods ranging from 6 to 23 years, an average of 12 years. These x-rays showed no abnormalities attributable to the inhalation of this dust and the group seemed to have better average health than 3,000 other employees not exposed to aluminum dust in equal concentration.

After this appraisal of exposure to aluminum dust, the authors returned to their specific task and carried out inhalation experiments with meticulous adherence to the rules of science and the careful selection and observation of cases through a clinic established for this specific purpose.

Omitting many interesting phases of the study for the sake of brevity, we close this brief editorial notice with the following summary from Crombie, Blaisdell and MacPherson.

"This investigation has shown conclusively that the administration of aluminum powder in the manner described is entirely harmless and has proved definitely beneficial in a number of cases under our observation. Out of 34 cases studied, 19, or 55 per cent, have shown clinical improvement, apparent chiefly in the lessening or disappearance of shortness of breath, cough, pain in the chest, and fatigue. A reduction in the incidence of colds and a gain in weight have also been observed in many of the cases. While 15 cases have remained stationary, it must be emphasized that they are no worse and their condition has not progressed, in spite of continuous employment in silica dust during the period of our investigation.

"Respiratory function tests, repeated at intervals of about every three months, have shown improvement in 12 or about one-third of the treated cases. While 22 remained stationary, they are no worse in spite of continued exposure to silica dust. A group of controls, untreated by aluminum, have shown progression of their disease in 66 per cent of nine cases while under observation.

"Aluminum dust cannot be regarded in any sense as a 'cure' for silicosis insofar as restoring to normal lung tissue which has already undergone fibrotic change is concerned. Its use, however, would appear to be followed by beneficial results in a significant proportion of cases, chiefly in the amelioration of symptoms and in the increased capacity to work. In view of these findings and the experimental work of Denny, Robson and Irwin, we believe the inhalation of finely particulate aluminum powder offers every prospect of preventing the development of human silicosis.

1. Denny, J. J., Robson, W. D., and Irwin, D. A.: Prevention of Silicosis by Metallic Aluminum. Canadian Medical Association Journal, 1937. Vol. 37, page 1.

2. Idem: Prevention of Silicosis by Metallic Aluminum. Canadian Medical Association Journal, 1939. Vol. 40, page 213.

3. Crombie, D. W., Blaisdell, J. L., MacPherson, G.: The Treatment of Silicosis by Aluminum Powder. Canadian Medical Association Journal, 1944. Vol. 50, page 318.

APROPOS BILL NO. 77

Medicine recognizes the growing need of a non-partisan Board of Health for the State of Oklahoma. But medicine would like for the people to know that such a bill is intended for their protection and not for the benefit of the doctors. Through such a Board designated to safeguard the people against disease and malnutrition, as ever, doctors are placing public safety above personal gain.

It seems difficult for legislators and many

of their friends to understand this attitude on the part of the medical profession. They do not realize that it is truly a medical tradition coming down through the Hippocratic Oath which placed the interest of the people above every other consideration and according to some historians marked a high point in the course of civilization.

Since public health has come largely through the medical profession and is wholly dependent upon medical science, it is logical and should be helpful to have non-medical members who believe in medical science on the Board. A veterinarian would be good because animal health is vital to human welfare, for example, the veterinarian's control of tuberculosis among dairy cattle. But to have so-called doctors who do not believe in medical science on a Board designed to apply the principles of this science would create an inexcusable paradox. The doctors are willing to devote time and talent and to make available all existing medical knowledge bearing on the functions of such a board but they are not pleased with the thought of working with people who openly oppose the principles upon which success must depend.

Attention is called to these two columns with the hope that medicine's position may be clarified.

A Few of the Contributions Medical Science Has Made to Public Health

The Contributions of Other So-Called Healing Arts to Public Health

1. The bacterial cause of disease.
2. Quarantine isolation and segregation.
3. The organization of public health agencies.
4. The establishment of clinics and hospitals for the poor and the indigent.
5. Cooperation in the establishment and operation of foundations including the Rockefeller Foundation inspired by Wm. Osler.
6. Health education.
7. Sanitary Engineering.
8. Preventive medicine

beginning with the vaccination against smallpox. (This one discovery means the addition of about three years to the life of every human being as long as time lasts.) Vaccination against typhoid fever and antitoxins for the control of diphtheria are equally important.

9. In the U.S. it has caused the death rate from tuberculosis to topple from its high position of 200 to 43.

10. It built the Panama Canal after everything else failed.

11. Today it makes the prosecution of the war possible through the control of malaria, yellow fever and other tropical diseases.

12. The contributions of penicillin and the sulfa drugs are indirectly influencing public health in that they control infectious diseases.

ACKNOWLEDGMENT

Representing the Oklahoma City Internists Meeting and the proposed Regional Meeting of the College of Physicians, Dr. Lea A. Riely desires to thank the publishers of the Medical Journals and Bulletins in adjoining states for their generous cooperation in announcing the proposed meetings in Oklahoma City, February 22-23. Although the meetings were called off by the Office of Defense Transportation, this Service is greatly appreciated.

Dr. John Abercrombie

Dr. John Brown in his 'Horæ Subsecivæ' says of him that the author of 'Diseases of the Brain and Nervous System' "was a master in the diagnosis and treatment of disease." He tells a curious story of how, while visiting with a student a man supposed to be labouring under malignant disease of the stomach, Dr. Abercrombie said, "The mischief is all in the brain." This proved to be the case, and on the student asking how Dr. Abercrombie discovered this, he said, "I can't tell you, I can hardly tell myself—I rest on past observation. My information would be useless to others, they must investigate for themselves." The student eagerly asked if it was something in the eye of the patient which guided his decision. "Perhaps it was," replied Dr. Abercrombie, "but don't blister every man's occiput whose eyes look like his."—*Aberdeen Doctors, At Home and Abroad*, pp. 110-111. Ella Hill Burton Rodger. William Blackwood and Sons. Edinburgh and London. 1913.

ASSOCIATION ACTIVITIES

ANNUAL STATE MEETING CANCELED

An application for permit to hold the Annual State Meeting was forwarded to Mr. R. H. Claire of the Office of Defense Transportation. The Committee, in reviewing the application, felt that the Meeting could reasonably be deferred until the necessity for the war-time restriction ends, therefore, the permit was denied.

It has been the request of the government that Conventions of more than 50 persons not be held in order to conserve transportation facilities for war needs.

OSBORN HONORED

Our own J. D. (Jim) Osborn of Frederick, Oklahoma, has been elected to the Executive Committee of the Federation of State Medical Boards for a period of three years. In addition, he has been made Chairman of a Committee to write a uniform Basic Science Law for the American Association of Basic Sciences.

These two significant, well-deserved personal honors represent not only recognition of Dr. Osborn's abilities but confer credit upon the medical profession and the State of Oklahoma. The importance of Oklahoma in national affairs receives little attention. Recognition comes hard. With this in view we are doubly indebted to Dr. Osborn for years of hard work in this field of endeavor which has won for him a place on these national boards.

LEGISLATIVE ACTION ON HOUSE BILL NO. 77

The House of Representatives has passed House Bill No. 77 providing for a State Board of Health with amendments providing for an osteopath and a chiropractor on the Board. However, the law still provides that there should always be a majority of doctors of medicine.

The Council gave this matter careful consideration and voted to leave the problem in the hands of the Public Policy Committee. It is still important that the members of the medical profession keep in close touch with the members of the Legislature in regard to this matter. As the Bill is now in the Senate, the efforts should be with the Senators as it will go back to the House and be considered there by a Conference Committee of possibly three or five members.

THE CORONER'S BILL

The Coroner's Bill has run into objections on the part of the justices of the peace. It is possible that a Crime Laboratory will be established at the Medical School which would afford expert facilities for the use of the justices of the peace when acting as coroners. It is possible that this would afford evidence in favor of the Medical Examiner System for the State.

DEAN LOWRY PRESENTS MEDICAL SCHOOL PROGRAM

Hearings before the joint Appropriations Committee of the House and Senate were held on February 20. Dean Lowry presented his request and announced all of the questions relative to the Medical School in a way that seemed to favor the members of the committee present.

All graduates of Oklahoma should urge their Senators and Representatives to support the Medical School Program as presented by Dean Lowry as it means much to the health of the State of Oklahoma and especially to the future medical care of the citizens including returning service men and their families.

DOCTORS AGAIN URGED TO SUPPORT MEDICAL ASSOCIATION LEGIS- LATIVE PROGRAM

Doctors coming to Oklahoma City for any reason should make it a point to call on their Representatives and Senators and explain to them the importance of the Medical Association Legislative Program.

At present it is the Board of Health Bill which is now in the Health Committee of the Senate and the Appropriations Bill for the Medical School which are now in the hands of the Appropriations Committee.

Please contact the Executive Office at any time for up-to-date information concerning the Program.

COUNCIL MEETING HELD IN OKLAHOMA CITY

On Sunday, February 11, 1945, the Council of the Oklahoma State Medical Association met in the Executive Office in Oklahoma City. Principal speakers included Hon. Robert S. Kerr, Governor and Senator Louis H. Ritzhaupt, both of whom spoke on the Legislative Program of Public Health.

WILLIAM E. EASTLAND, M.D.

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RESOLUTION

WHEREAS, Dr. J. I. Hollingsworth, an honored member of the Jefferson County Medical Society has been called from his field of labor among us,

BE IT RESOLVED by this organization to which he gave so much faithful service, that we give expression of our keen sense of loss at his passing by spreading upon the minutes of our Society these resolutions of respect. Dr. Hollingsworth was not only a great physician and surgeon, one devoted to his profession and with a keen sense of responsibility for those who entrusted their care to him, but he was a friend, to be loved and trusted under all circumstances. We miss him, in our consultations of course, but still more as a real friend.

BE IT FURTHER RESOLVED that a copy of these resolutions be spread upon the minutes of our organization, a copy furnished to his widow and a copy furnished the Waurika News-Democrat for publication.

The Jefferson County Medical Society
F. M. Edwards, M.D., President
J. I. Derr, M.D., Secretary.

TULSA DOCTOR HIJACKED

Shortly after midnight on February 3, Dr. Andre B. Carney, Tulsa, was kidnapped as he was leaving Hillcrest Hospital. He was taken to the Turkey Mountain area where he was tied to a tree. The bandits escaped after relieving Dr. Carney of his money and car. After several hours, he was able to free himself and walk to where he could notify the police.

Within the week the police captured two Army deserters who proved to be the ones responsible for the robbery and kidnapping.

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DISTRICT COUNCILOR REPORTS

ANNUAL REPORT OF DISTRICT NO. 1

To the President and House of Delegates
Oklahoma State Medical Association
Gentlemen:

In accordance with the By-Laws of the State Association, I herewith present my annual report as Councilor of the First District.

1. I have assisted in getting all the physicians of the District to renew their membership in the State Association and in the collection of their annual dues. I have visited all counties of the district except Beaver, Texas and Cimarron. I also wrote to all the members relative to the sale of government bonds in the Fifth War Loan drive in July.

2. I attended four meetings of the Woods County Medical Society in Alva. At one of these meetings held on November 20, I was instrumental in linking up the Medical Society with the Crippled Children's Clinic which was sponsored by the Alva Rotary Club. It was very successful and helped link up the County Medical Society with the civic organization.

3. I attended one meeting at Cherokee with the Woods County Society meeting with the Alfalfa Society.

4. I attended two meetings of the Woodward County Society at Supply, one of which was a District wide meeting with about 100 members and guests present. Senator Williams was present and gave a talk expressing himself as in perfect harmony with the medical profession. At this meeting were President C. R. Rountree, President-Elect V. C. Tisdal, Dr. John W. Shackelford of the State Health Department, Dr. Tom Lowry, Dean of the Medical School, and Mr. Paul H. Fesler, Executive Secretary. Each guest discussed subjects highly pertinent to the state organization.

5. We have in the First District two active societies. The Woods County Society holds regular meetings bi-monthly on the last Tuesday of each odd month. It has four members from outside the county and four associate members from the adjoining county in Kansas. Woodward County Society has shown good activity and meets every three months in different towns drawing members from Harper, Beaver and Ellis Counties. Alfalfa is mildly active and has had one meeting during the year, meeting with the Woods County Society the rest of the year. Texas County has an organization but to my knowledge has had no meeting. Cimarron has no organization as there is only one doctor in the county.

6. I attended the Annual Meeting at Tulsa on April 24, 25 and 26, 1944. I have attended Council Meetings in Oklahoma City on July 9 and October 22, 1944, and February 11, 1945.

Respectfully submitted,

O. E. TEMPLIN, M.D.
Councilor, District No. 1.

ANNUAL REPORT OF DISTRICT NO. 2

To the President and House of Delegates
Oklahoma State Medical Association
Gentlemen:

The following is a brief report from the Second Councilor District:

In December, a meeting of the Second Councilor District membership was held at Hobart at which time about 25 doctors were in attendance. The program consisted of an explanation of the proposed legislative program by Dr. V. C. Tisdal, Dr. C. R. Rountree, Dr. Floyd Keller and Dr. J. D. Osborn.

Legislators and Representatives from this District have

been contacted and informed of the importance of and our desires toward proposed legislation.

Respectfully submitted,

J. WILLIAM FINCH, M.D.
Councilor, District No. 2.

ANNUAL REPORT OF DISTRICT NO. 3

To the President and House of Delegates
Oklahoma State Medical Association
Gentlemen:

It has been my privilege and a pleasure to me to act as Councilor for the Third District during the past year.

I regret very much that I was unable to personally visit each County Society; however, by letter and telephone, I have kept in touch with the activities of the members of this District; namely, Garfield, Kay, Noble, Pawnee, Grant, Major and Payne. Grant and Major Counties have very few doctors each, and Major County is affiliated with the Garfield Society.

As of this date, February 1, there is a total of ninety-one members in District No. 3. Of this number twenty-six are now serving in the armed forces — Garfield, 10; Kay, 10; Noble, 1; and Payne, 5.

On December 22, 1944, at the request of the State Office, a District Meeting was held in Ponca City. Invitations were issued not only to the Presidents of the County Societies but each doctor received a personal letter of invitation. We also invited the legislators of the respective counties. It is my belief that we, as medical men, possess information needed by our law makers, and that no other group is qualified by education and experience to carry the responsibility of speaking with authority on medical matters. The meeting was well attended by both doctors and legislators. A very interesting program of legislative problems of the medical profession was presented. The legislators not only expressed sincere interest in our problems, but assured us of a willingness to assist whenever possible. Guest speakers for this occasion were Dr. C. R. Rountree of Oklahoma City, President of the Oklahoma State Medical Association; Dr. V. C. Tisdal of Elk City, President-Elect; Dr. W. Floyd Keller, Oklahoma City, Professor of Legal Medicine of the University of Oklahoma School of Medicine; Dr. Tom Lowry, Oklahoma City, Dean of the University of Oklahoma School of Medicine; Dr. John F. Burton, Oklahoma City, and Paul Fesler, Executive Secretary of the State Association.

As Councilor of District No. 3, I have encouraged regular meetings of the County Societies and have assisted wherever possible in the collection of the annual dues.

The entire membership of this District has been most cooperative. It has been a genuine pleasure to work with these doctors, and at this time, I wish to express my sincere appreciation for their support and cooperation.

Respectfully submitted,

C. E. NORTHCUTT, M.D.
Councilor District No. 3.

ANNUAL REPORT OF DISTRICT NO. 4

To the President and House of Delegates
Oklahoma State Medical Association
Gentlemen:

In accordance with the custom established by the By-Laws, the Councilor of the Fourth District herewith submits a brief report for the past fiscal year.

On January 12, 1945, a Councilor District meeting was held at the Skirvin Hotel in Oklahoma City with ap-

FEWER nocturnal insulin reactions

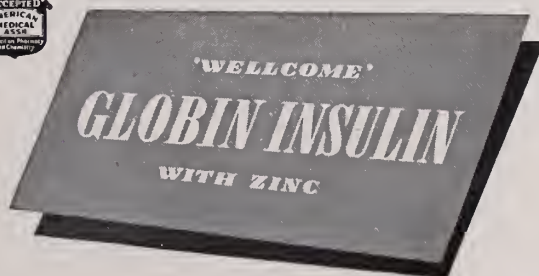


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proximately 50 in attendance. All Counties in the District were represented. Following introductory remarks by your Councilor, Dr. C. R. Rountree, President of the State Association, after briefly outlining the activities of the executive office, presided.

Dr. V. C. Tisdal, Chairman of the Public Policy Committee, presented the legislative program of the Association. Supplementary remarks in behalf of the State Board of Health were offered by Dr. John W. Shackelford; Dr. J. D. Osborn discussed the Basic Science Certificate bill; Dr. W. Floyd Keller outlined the Medical Examiner System proposed to replace the coroner system; and the undersigned, as Dean of the University of Oklahoma School of Medicine, presented the budget for the Medical School and discussed the proposed enlargement of the Medical School.

Your Councilor, who is Chairman of the Post-War Planning Committee of the Association, in turn outlined the work of the Committee and pointed out that, in connection with a like Committee of the Medical School and the Postgraduate Medical Teaching Committee of the Association, plans were being made for a training program for returning Service Members.

Dr. John F. Burton briefly discussed the progress of the Prepaid Surgical and Obstetrical Plan.

Two legislators; namely, Representatives Paul Washington and Creekmore Wallace, were present and expressed opinions of approval concerning the evening's discussion.

Your Councilor along with other Officers of the Association has attended the following Councilor District meetings in an attempt to acquaint the physicians of the State with existing problems: No. 1 at Alva, No. 2 at Hobart, No. 3 at Ponca City, No. 5 at Chickasha, No. 7 at Shawnee, No. 9 at McAlester and No. 10 at Durant.

It was indeed a pleasure to visit with friends out over the State, and it is regretted that this procedure cannot be followed more often. Likewise, it has again been a sincere pleasure to represent the profession of the Fourth District as Councilor during the past year.

Respectfully submitted,

TOM LOWRY, M.D.
Councilor, District No. 4.

ANNUAL REPORT OF DISTRICT NO. 5

To the President and House of Delegates
Oklahoma State Medical Association
Gentlemen:

Following the death of Dr. J. I. Hollingsworth of Waurika on November 30, 1944, the undersigned was appointed by the Council of the Association, upon nomination by the members of the Fifth District, to complete the unexpired term caused by the untimely passing of Dr. Hollingsworth.

A Councilor District meeting was held in Chickasha, December 1, 1944, at Harry's Cafe, with Dr. C. R. Rountree, President of the Association, presiding.

In the absence of the Public Policy Committee Chairman, Dr. V. C. Tisdal, Dr. Rountree presented the proposed legislative program. Dr. Tom Lowry, Dean of the University of Oklahoma School of Medicine and Chairman of the Post-War Planning Committee of the State Medical Association, discussed the work of his Committee with reference to post-war planning for returning Service physicians.

Dr. John F. Burton was unable to attend; however, a lengthy discussion pertaining to the prepaid surgical

and obstetrical plan of the Association adopted by the House of Delegates on October 22, 1944, followed. Paul H. Fesler, Executive Secretary, answered many of the questions that were propounded.

Members present stood in a moment's silence in respect for Dr. Hollingsworth — the sad news of his sudden death being a surprise to all of us in attendance.

The meeting was well attended and almost every County in the District was represented. The meeting afforded members present an opportunity to acquaint themselves with legislation coming up during the Twentieth Legislature. The information was enthusiastically received with each member expressing opinion that he would do his utmost to put the program over.

Respectfully submitted,

JAMES L. PATTERSON, M.D.
Councilor, District No. 5.

ANNUAL REPORT OF DISTRICT NO. 6

To the President and House of Delegates
Oklahoma State Medical Association
Gentlemen:

It may sound like an old story to speak of travel restrictions of tire and gasoline rationing still preventing the visits which a Councilor should make to the Societies in his District, but it is to be hoped that by the time another year rolls around the war will be so nearly over that these difficulties will have faded away.

From reports sent me by the various secretaries, I learn that the Societies have kept up their usual meetings and have had about the usual average attendance. Scientific programs have been good.

Two Societies in the District, Rogers and Washington-Nowata, had the postgraduate lectures on surgery given last spring with a very good attendance.

It is to be regretted that little has been done in any of the Societies of this District in support of, or promotion of the "Prepaid Medical Plan" or the medical legislation which proposes to establish a Board of Health to supercede the present Health Commissioner system, except in the Tulsa County Society, which has worked long and faithfully for both of these measures.

Death has depleted the ranks of some of the Societies. Two have died in the Washington-Nowata Society, one in the Creek County Society, and two in the Tulsa County Society.

Respectfully submitted,

J. V. ATHEY, M.D.
Councilor, District No. 6.

ANNUAL REPORT OF DISTRICT NO. 7

To the President and House of Delegates
Oklahoma State Medical Association
Gentlemen:

Your Councilor from the Seventh District wishes by this means to recall to your attention the unselfish devotion and activities of two members who served the Oklahoma State Medical Association long and well, who are with us no more, except in spirit. Doctor William L. Taylor of Holdenville and Doctor John A. Walker of Shawnee have finished the course. They were consistently interested in doing whatever they were able to improve the practice of medicine in this State. Whatever their shortcomings or weaknesses may have been are shared by all of us, but their example of participation to the fullest of ability should always be a challenge to us who remain that we should recognize the great unfinished

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apparently must be maintained at a level above normal in order to assure proper wound healing* and at least average resistance against infection.** The feeding of meat, therefore, in adequate amounts, as soon as it can be instituted, appears doubly advantageous: the protein content of meat is high and of highest biologic value; the human digestive tract appears well adapted for handling meat protein.**

*" . . . in a variety of medical and surgical conditions there may occur a considerable depletion of body protein owing to a combination of factors, of which the two most important are a generally diminished protein intake and an enhanced protein catabolism. This situation inhibits wound healing, renders the liver more liable to toxic damage, impedes the regeneration of hemoglobin, prevents the resumption of normal gastrointestinal activity and delays the full return of muscular strength. It is obvious that to meet the situation an adequate supply of proteins and calories must be made available to the body. . . . This implies at least 150 Gm. of protein and 3500 calories, with as much as 500 Gm. of protein daily when trauma has been severe, as in serious burns." (HOFF, H. E.: *Physiology*, New England J. of Med. 231:492 [Oct. 5] 1944.)

**"Cannon . . . cites the evidence which indicates that diminished protein intake lowers resistance to infectious disease, and corroborates it by his own experiments . . . it seems probable that the small intestine is better adapted for handling protein (especially meat protein) than for other types of food. . . . it is especially well supplied with enzymes which attack protein, and the digestion of meat has been shown to be more complete than that of foods of vegetable origins." (CRANDALL, L. A., Jr.: *The Clinical Significance of the Plasma Proteins*, *Memphis M.J.* XIX:147 [Oct.] 1944.)

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work which they have tried to advance. There is much to be done, and many more of us could contribute more, according to our respective and relatively undeveloped abilities.

Your Councilor wishes also to acknowledge extreme satisfaction for the cooperative assistance which the Seventh District has given the various activities of the Oklahoma State Medical Association—for the prompt and adequate response which has met or anticipated each appeal for support of the several functions of the State organization. The record of accomplishments of the Oklahoma State Medical Association during the past year should be rich in appreciation of the substantial contributions of the members of the Seventh District. It is with a sense of pride for this district that your Councilor acknowledges with personal satisfaction that you have asked him to be your representative. With humility and deliberation he has tried to serve your best interests, and at all times solicits your further help and suggestions.

Respectfully submitted,
CLINTON GALLAHER, M.D.
Councilor, District No. 7.

ANNUAL REPORT OF DISTRICT NO. 8

To the President and House of Delegates
Oklahoma State Medical Association
Gentlemen:

The activity of the Eighth Councilor District of the Oklahoma State Medical Association during the last year has necessarily been curtailed, however, on December 29, 1944, there was an excellent meeting held at Vinita through the courtesy and kindness of Dr. F. M. Adams who furnished a meeting place and an excellent meal.

Dr. C. R. Rountree, President, and Dr. V. C. Tisdal, President-Elect and who is also Chairman of the Public Policy Committee, discussed in much detail the activities and desires of the State Medical Association among which was a proposed legislative program and a discussion on the prepaid Surgical and Obstetrical Plan that is in the process of being inaugurated. There was a good attendance from the large part of the District and the meeting accomplished a great deal of good.

Respectfully submitted,
FINIS W. EWING, M.D.
Councilor, District No. 8.

ANNUAL REPORT OF DISTRICT NO. 9

To the President and House of Delegates
Oklahoma State Medical Association
Gentlemen:

A meeting of the Ninth Councilor District was held in McAlester on December 8, 1944, with a good representation of the District present. The group met at 7 p. m. at which time the ladies of the Grand Avenue Methodist Church served a wonderful meal, after which the meeting was called to order by your Councilor who briefly stated the purpose of the meeting and the desire of the officers of the association to acquaint the members with the work being done by the association. The meeting was then turned to our guests with Dr. C. R. Rountree, President of the State Medical Association, presiding.

Dr. Rountree gave a report on the condition of the Association after which he called upon Dr. Tom Lowry, Dean of the University of Oklahoma School of Medicine and Chairman of the Post-War Planning Committee. Dr. Lowry told of the work the Committee has done and of the responses received from the Doctors in the service and of their desires for Internships and Residencies as well as Postgraduate and Refresher Courses. This Committee is working hard to see that our Doctors in the Armed Forces may be able to get the type and kind of service they desire upon their return to Oklahoma.

Dr. V. C. Tisdal, President-Elect, was then introduced and took up the Legislative Program which is to be submitted to the 1945 Legislature. Dr. Tisdal called upon

Dr. John W. Shackleford who outlined and explained briefly the bill creating the State Board of Public Health as provided in the Constitution, stating that Oklahoma is one of the three states in the United States without a board. This bill will eliminate the custom of changing the Commissioner of Health with each change of administration at the Capitol.

Dr. W. Floyd Keller, Professor of Legal Medicine at the Medical School, then explained the proposed Coroner's Bill pointing out the necessity of a Doctor of Medicine being the Coroner as he alone is qualified to act in that capacity.

Dr. Tisdal then explained the Basic Science Certificate Bill which would permit the issuance of a Basic Science Certificate to any Doctor who was in active practice in 1937 when the Basic Science Law was enacted and who is in good standing at the time he makes application for the Certificate and upon the payment of the required fee.

Dr. John F. Burton reported on the Prepaid Medical and Surgical plan, stating the plan would be placed in operation as quickly as possible following the meeting of the Board of Trustees, the personnel of which he announced.

We were also very glad to have Mr. Paul Fesler, Executive Secretary of the Association, present at the meeting.

Guests of your Councilor were State Senator M. O. Counts and Representatives, Plowboy Edwards and Hiram Impson, who were called upon and expressed their pleasure at being present to learn first hand of the Legislative Program.

Respectfully submitted,

L. C. KUYRKENDALL, M.D.

Councilor District No. 9.

ANNUAL REPORT OF DISTRICT NO. 10

To the President and House of Delegates
Oklahoma State Medical Association
Gentlemen:

The Tenth Councilor District is composed of eight counties; namely, Atoka, Coal, Choctaw, Bryan, Johnston, Marshall, McCurtain, and Pushmataha. Most of these counties have been visited and those that have not have been contacted by telephone or mail.

Some of the counties in this District are small and the membership in some have been depleted by deaths and by others going into the armed service of the Country. An effort has been made to merge or combine some of the smaller county societies and this recommendation has met with much encouragement. Two have already been combined, and it is hoped in the near future that some others can be merged which, evidently, will be mutually advantageous to all physicians concerned.

A general meeting of Councilor District No. 10 was held in Durant on the evening of December 9, 1944. This meeting was sponsored by the Bryan County Medical Society at which a fine quail supper, furnished complimentary by Dr. W. K. Haynie, Secretary of the Society, was served.

In spite of the inclement weather, the meeting was well attended, a fairly large representation being present from over the district. The meeting was greatly honored by the presence of Dr. C. R. Rountree, Oklahoma City, President of the Oklahoma State Medical Association; Dr. V. C. Tisdal, Elk City, President-Elect of the Oklahoma State Medical Association; Dr. Tom

Lowry, Oklahoma City, Dean of the University of Oklahoma School of Medicine; Mr. Paul Fesler, Executive Secretary of the Oklahoma State Medical Association and Dr. John W. Shackleford of the State Health Department. Also, present as honored guests were Hon. Bayless Irby, State Senator from this Senatorial district, and Hon. William Parrish, Representative in the State Legislature from Bryan County.

One of the objects of the meeting was to acquaint the physicians of this section of the state with the proposed legislative program as outlined by the Oklahoma State Medical Association — the different phases of which were ably presented by the above physicians and Mr. Fesler. The meeting was in charge of Dr. Rountree who presided with ease and speed. Many questions were asked and answered, and the meeting was full of interest from start to finish. The finest fellowship and hospitality prevailed, and we believe the meeting was most helpful and beneficial, and it is hoped that another meeting can be arranged next year for our District.

Many of our endeavors have been restricted and our enthusiasm has been somewhat dampened by the exigencies of war conditions and the resulting added duties and increased responsibilities imposed on physicians at home. However, in spite of these unfortunate conditions and handicaps, we believe progress has been made, and for all these accomplishments, due credit and appreciation should be expressed to the many capable, aggressive, and loyal physicians who have cooperated fully and who have carried heavy loads uncomplainingly with unfailing inspiration to us all.

Respectfully submitted,

JOHN A. HAYNIE, M.D.

Councilor, District No. 10.

WYETH PENICILLIN LABORATORIES STUDIED BY BRAZILIAN CHEMISTS

The penicillin laboratories of Wyeth Incorporated, Reichel Division, at West Chester and Kimberton, Pa., have been selected as ideal for the study of penicillin manufacturing methods by Dr. Jesuino de Albuquerque, Secretary of Public Health of the Federal District of Rio de Janeiro, Brazil, who is in this country gathering data for the establishment of a municipal penicillin laboratory in Rio.

Dr. Albuquerque, who is here on a mission for President Vargas, of Brazil, and is investigating U. S. penicillin manufacturing methods at the request of Mayor Dodswoth, of Rio, chose the Wyeth penicillin laboratories for special study because, according to him, "from the standpoint of both facilities and processing they provide the ideal pattern for us to adopt in Rio."

In cooperation with the Wyeth staff, arrangements have been made for a group of Brazilian chemists and bacteriologists to study the production and standardization of penicillin at Wyeth. The Wyeth organization has made the facilities of its Philadelphia, West Chester and Kimberton laboratories available to the Brazilian scientists for this purpose.



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★ FIGHTIN' TALK ★

MAJOR HARRY C. FORD, Oklahoma City, is amusing himself (in what little spare time he has) by taking in the sights of Gay Paree! He says that he has recently seen MAJOR LOU CHARNEY and that both of them are ready to "call in the dogs and go home." Thanks for the nice letter, Dr. Ford.

LT. (jg) JOHN L. DUER, Woodward, serving in the Navy Medical Corps, was wounded during the first day of the Iwo Jima battle.

LT. COL. WILLIAM N. WEAVER, Muskogee, has been recently promoted from Major.

CAPTAIN ROGER REID, Ardmore, writes from his station in England and reports that he is receiving the Journal and newsletter and is passing them on to an English surgeon as their supply of current literature is limited.

CAPTAIN FOWLER B. POLING, Hollis, was married on February 13 to Miss Betty Ann Bowden of Douglas, Arizona. Captain Poling graduated from the University School of Medicine in Oklahoma and interned at the University of Iowa hospital in Iowa City.

After the wedding, Captain and Mrs. Poling went to Orlando, Florida, where Captain Poling will have a special course in plastic surgery. They will then return to Douglas, Arizona.

LT. J. D. ASHLEY, JR., formerly at University Hospitals in Oklahoma City, writes as follows from his overseas station "At rare intervals I have run across MAJOR PAT NAGLE, CAPTAIN STANLEY SELL AND LT. FLORINE CRAIG (Dietitian from the University Hospitals) but their contacts with home have been as scant as mine. Major Nagle is Chief of the Surgical Section in an Evacuation Hospital, Captain Sell is Chief of the Orthopedic Section in a General Hospital in England. I bear the exaggerated title of Chief of Neuropsychiatric Section of our unit."

LT. (jg) BYRON W. AYCOCK, Lawton, has a new daughter, born February 20 at Oklahoma City. Glenda Jane is the name chosen for the new arrival who has a two-year old brother, Alan. Mrs. Aycock and children are living in Lawton. Lt. Aycock is stationed at Attu.

The following release concerning the unit of CAPTAIN CLIFTON FELTS, Seminole, comes from the Headquarters of the Peninsular Base Section. Captain Felts was commissioned in the Medical Corps as First Lieutenant in June, 1942 in Oklahoma and was promoted to his present rank in February, 1943. While serving as Battalion Surgeon in an Infantry Division in Italy he received a Citation on May 30, 1944 for "Heroic and Meritorious duty beyond the ordinary in action." He has been overseas since December, 1943 and in his present unit since July, 1944. He graduated from the University of Illinois College of Medicine in 1932.

RELEASE

Peninsular Base Headquarters, Italy:—Captain Clifton Felts, former Associate Physician at Pace Chambers Clinic, Seminole, Oklahoma, is serving as Assistant Chief of Medical Service with a Station Hospital of this Base which in twenty months overseas has treated approximately 15,000 patients while operating in Algeria and Tunisia in North Africa and during its present tour in Italy.

One of the first Station Hospitals to be sent to the Mediterranean Theater, the unit's first assignment took

it to Ain Mokra, a village near Bone, Algeria, and two months later the hospital was ordered to Ferryville, Tunisia, where the organization remained ten months before reaching Italy in June, 1944.

It was at Ferryville that an abrupt departure from the customary mission of a Station Hospital was authorized, changing the organization overnight from a 500-bed unit to a 3,000-bed convalescent installation which a short time later became a "conditioning center." Immediately adapting themselves to new and increased specialized duties, officers and men were responsible for the reconditioning, mentally and physically, of thousands of front-line troops who had reached a convalescent stage and were being returned to combat duty after recovery was complete. In addition to this function, the hospital admitted service troops from a wide surrounding area.

Moving to Italy, unit members already have earned their first bronze battle star by opening their hospital on an important communication line behind the front. Here they received, within twelve days, 650 patients, mostly from adjacent evacuation hospitals, which were thus enabled to pack up and move forward. A census of these patients revealed that the following thirty-one languages comprised the list of "native tongues": Abyssian, Afghan, Albanian, Arabic, Bohemian, Bulgarian, Chinese, Danish, Dutch, Finnish, Flemish, French, German, Greek, Hindu, Hungarian, Italian, Japanese, Lithuanian, Norwegian, Persian, Polish, Portuguese, Punjabi, Roumanian, Russian, Serbian, Spanish, Swedish, Burmese, Turkish, and an assortment of African dialects. Nurses and ward men soon became expert in the sign language.

At present, patients are finding themselves comfortably installed in a former tuberculosis sanatorium, an imposing structure of modern and convenient appointments.

Because of the frequency of moving, hospital personnel have become skilled in "tearing down and setting up," and in the spirit of typical Yankee humor have labeled the organization "Ringling Brothers." Assembling vast amounts of equipment and supplies along with installing utilities with a minimum of delay has repeatedly tested the ingenuity of both the professional and enlisted staffs. In face of fire and flood the hospital has remained in operation without a moment's interruption. While in Africa a forest fire of serious proportions threatened to sweep the area, but by enlisting the help of every English, French, and Arab soldier in the vicinity, hospital personnel brought the fire under control within a scant two hundred yards of the hospital site. In Italy, flood waters raced into the area and within a half-hour reached a depth of five feet in the hospital basement. Large amounts of supplies were destroyed or damaged, but by wading almost neck-deep through a labyrinth of rooms and halls, personnel removed and saved many critical supplies.

The hospital was activated at Fort Knox, Kentucky, in December, 1942, and in April, 1943 sailed for North Africa. Nucleus of the organization is a group from Massachusetts, Maine, and Connecticut, which reported to Fort Knox shortly after activation. Since then, officers, nurses, and enlisted men have been assigned to the unit from all sections of the United States.

Commanding the hospital is Colonel G. P. Lawrence of Westerville and Columbus, Ohio. Colonel Lawrence, a graduate of the Rush Medical College in Chicago, commanded an ambulance company in World War I.

The well known little bird has been flying around and has left a message that *maybe* the office will get a visit from CAPTAIN DICK GRAHAM, within a week. Ot

course, we are all hoping that it is true and if so, a report will be in this column next month. Dick is still in the Surgeon General's Office in Washington and is being kept plenty busy. In a recent letter he says, "Tell them that we desk chair 'Generals' know d—— well who is fighting the War and deserves all the credit."

Again quoting from the letter, "LT. COLONEL WAYNE STARKEY, Altus, and myself seem to be the only ones left here as LT. COLONEL McDONALD, Ada, and MAJOR LINGENFELTER, Clinton, have gone overseas in the S. W. Pacific for duty with Civil Public Health. I imagine you know that MAJOR JACK RECORDS (Oklahoma City) and MAJOR CHARLES WILSON (Oklahoma City) have left Carlisle Barracks and are now attending special schools. Major Records took the neurosurgery course at the Army Medical Center, Washington and is now at Lawson General Hospital and Major Wilson was to take a course in Surgery and then be assigned to the 8th Service Command."

LT. TURNER BYNUM, U.S.N.R., Chickasha, writes as follows, from the Marianna Islands: "When coming ashore here, transferring from the transport to an L.C.T., I received a small avulsion fracture of my left os calcis (heel) which put me in the hospital for three weeks. Since leaving the hospital I have been fortunate enough to get to work with the natives in dispensaries in the villages and in the civilian hospital where I have had the opportunity of observing many interesting conditions while awaiting my hospital unit's going out on an operation."

"AARON LITTLE of Minco is here as a regimental surgeon with the Marines. I have seen him several times. There are several Army and Navy hospitals here but I have not located any other Oklahoma doctors among them."

MAJOR B. J. CORDONNIER, Enid, is now in France. He says that his outfit is fairly new in the European Theatre of Operations but that they expect to be very busy before long. The unit has good equipment and good personnel and Major Cordonnier says that he hopes that they will be a real help.

Another letter from France, comes from MAJOR ROBERT E. ROBERTS, Enid, who sends in quite a bit of news about fellow Oklahomans:

"Just now I am on detached service at ———— Evacuation Hospital whose Commanding Officer is COLONEL FENTON SANGER (Oklahoma City) and whose Assistant Chief of Medical Service is MAJOR 'BILL' MERCER (Enid). They are doing a swell job with their unit and it makes a fellow Oklahoman quite proud of his Alma Mater's products. Colonel Sanger tells me that COLONEL N. L. MILLER, Oklahoma City, gets around once in a while and that COLONEL 'BUCK' ENSEY (Altus) is near here. I had begun to think that all of Oklahoma's doctors were in the Pacific or Italy because the only others I had seen were COLONEL T. A. RAGAN (Fairfax) and MAJOR M. M. APPLETON, Oklahoma City, during the 15½ months I've been overseas. It is great to see these fellows and thought perhaps you might be interested in their whereabouts."

Looks like we owe Major Roberts a "coke" for all that news!

Again we hear from MAJOR PAT NAGLE who is now in England after having been stationed at Camp Polk in Louisiana for a while. Major Nagle was sent to Camp Polk after having served a long stretch in the South Pacific. We imagine the scenery to be very different than his former trip abroad! In his letter he says, "I find England cold but green and beautiful. Was called into this unit as Chief of Surgery and find it an unusually good unit."



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COMMITTEE REPORTS

REPORT OF COMMITTEE ON INSURANCE

The Committee on Insurance submits the following report to the House of Delegates:

During the past year, your Committee on Insurance has studied the idea of developing a group health and accident policy for the members of the State Association. Investigation has been made concerning what has been done in other states along this line, and it has been determined that the trend all over the United States is to accept some type of health and accident policy — sometimes as a group policy for the County Society separately and frequently for the State Association as a whole.

Following further research prior to definite decisions and recommendations, the Committee feels it will have something very valuable to offer the doctors of Oklahoma, and regardless of what type of health and accident program the individual doctor might have he can well afford to investigate the proposed program.

In line with procedure followed during the past two years, your Committee has continued to work with and advise the London and Lancashire Indemnity Company, represented by the local agents Eberle and Company, Oklahoma City, with reference to the Group Malpractice Insurance Policy of the Association. The cooperation of local county committees with respect to approval of members is sincerely appreciated.

It is noted that individual physicians from 50 of the 77 counties in the state participate in this program. In checking over the names of those who hold certificates, it is also observed that 30 of those members who are in the Armed Forces have continued to carry malpractice insurance under the Group Policy.

Upon further checking the records in the insurance company, the Committee is advised that seven claims for malpractice were filed during 1944 of which six have been settled. Also, there are on record five claims filed prior to 1944 which are still pending.

The Committee feels that the Presidents of each County Society are failing to put enough emphasis on this program and as a result the members of his Society are not getting the greater benefits which the policy offers and the minimum rates offered. The Committee feels that if each Society would make the effort to familiarize the members with the many advantages offered by this group policy by having the local representative of London and Lancashire to explain it, many more policies would be written.

The Committee feels that this program should be more loyally supported and unless a doctor is especially obligated to the local representative of a competing company he should have this insurance or find some good reason why he should not support this program. It is because of this program that he is paying much less now for his malpractice insurance than he did five years ago.

Because of the reduced rates due to the fact that only members of the Association can participate in the Group Policy, your Committee recommends that all local County Societies urge their membership to secure the benefits of this program.

Respectfully submitted,

V. K. Allen, M.D., Chairman
J. T. Phelps, M.D.
LeRoy D. Long, M.D.

REPORT OF COMMITTEE ON LIBRARY

The Committee on Library submits the following report to the House of Delegates:

Your Library Committee desires to report satisfactory progress under the rules and regulations adopted by the Council at its meeting on October 22, 1944.

Miss Anne Betcher, custodian, reports the following publications now available: Exchange of Journals with Other State Medical Associations 36—further designated as follows: Single States 31; District of Columbia 1; Southern Medical 1; Journal Lancet representing four states 1; Rocky Mountain Medical representing three states 1 and Northwest Medicine representing three states 1. Foreign Exchanges 3; namely, South African Journal of Medical Sciences, Proceedings of Royal Society of Medicine and Clinical Proceedings (Africa). County Bulletins 9 as follows: State of Oklahoma—Oklahoma, Tulsa and Pottawatomie; State of New York—Nassau, Westchester and New York; Sedgwick County, Kansas; Wayne County, Michigan, and Jackson County, Missouri.

Special Bulletins and Publications as listed: Therapeutic Notes, Medical Times, Journal of the International College of Surgeons, Federation Bulletin, Bulletin of Maryland School of Medicine, Stanford Medical Bulletin, Digest of Ophthalmology and Otolaryngology, Bulletin of National Tuberculosis Association, Venereal Disease Information, National Foundation News, Crippled Child Bulletin, News Letter from Oklahoma Society for Crippled Children, Nutrition News, State Health Department, Statistical Bulletin of Metropolitan Life Insurance Company, Woman's Auxiliary to the American Medical Association and Sooner Magazine.

Paid Subscriptions to Survey and Survey Graphic, Hygeia, Journal of Industrial Medicine, American Journal of Public Health, American Journal of Medical Sciences, University of Minnesota Staff Medical Bulletins, The Modern Hospital, Hospital Management and Hospitals. Books Purchased include The Hospital in Modern Society and Physician's Handbook. Quarterly Cumulative Index Medicus of the American Medical Association from 1939 to date lacking the first half of 1939 and first half of 1941 and prior to that time, an incomplete set of the Index has been loaned for use by the University of Oklahoma School of Medicine Library.

The Committee acknowledges the following contributions from Dr. Henry H. Turner: Journal of the American Medical Association for the years 1939, 1940, 1941, 1942 and 1943, and Medical Clinics of North America for the years 1920-1939.

In addition to the above, there are additional files on general subjects.

The Committee has been assured that the Library is proving to be increasingly serviceable to the Editorial Board and the office staff.

Respectfully submitted,

Lea A. Riely, M.D., Chairman
Basil A. Hayes, M.D.
L. J. Moorman, M.D.

REPORT OF COMMITTEE ON MATERNITY AND INFANCY

The Committee on Maternity and Infancy submits the following report to the House of Delegates:

A meeting of the Committee was held in Oklahoma City early in January, 1945, at which time plans for the coming year were discussed. It was the opinion of the Committee that the study on maternal mortality should continue and all data now in the hands of the Committee be studied and the information obtained from this study should be published and made available to the practitioners of Oklahoma.

Continued efforts are being made to inform the leading educators in the field of education and religion to

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Corn
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Cucumber
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Eggyolk
Flounder
Gelatin
Ginger
Grape (Raisin)
Grapefruit
Halibut
Herring
Honeydew
Lactalbumin

Lamb
Lettuce
Lima Bean
Lobster
Mackerel
Milk (Cow)
Mushroom
Mustard
Oat
Onion
Orange
Oyster
Pea
Peanut
Pecan
Pepper
(Red, Green)
Perch
Pike
Pineapple
Pork
Potato
Prune (Plum)
Pumpkin
Quince Seed
Radish
Rice
Rye
Salmon
Sardine
Scallop
Shrimp
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make available to them the factual information contained in the studies of maternal mortality, with the view to utilize this material in a statewide campaign to educate the pregnant woman to report early for antepartum care to avoid the abortionist, and to seek as early as possible the best possible medical supervision throughout her pregnancy.

Your Committee reviewed the plan of the Oklahoma State Health Department to provide penicillin for obstetrical patients without cost to the patient or hospital. The Committee assumed the responsibility for determining the types of penicillin sensitive organisms for which penicillin may be used under this plan.

Your Committee feels that valuable information could be obtained from a study of infant mortality, conducted in a similar manner as the study on maternal mortality. This problem would probably necessitate the appointment of an additional committee to adequately study the infant deaths in Oklahoma.

Respectfully submitted,

J. T. Bell, M.D., Chairman
Edward N. Smith, M.D.
Gerald Rogers, M.D.
Catherine Brydia, M.D.

REPORT OF MEDICAL ADVISORY COMMITTEE TO THE STATE DEPARTMENT OF PUBLIC WELFARE

The Medical Committee submits the following report to the House of Delegates:

The Medical Advisory Committee continues its meetings regularly, but the definition of policy and activity has been so well accomplished that it is no longer necessary to meet more often than four or five times a year. During the intervals between meetings, each member reviews the cases which are submitted from his district at intervals of approximately one week. The personnel of the Committee at present is as follows: Clinton Gallaher, M.D., Shawnee, Chairman; Mack I. Shanholtz, M.D., Wewoka; R. M. Shepard, M.D., Tulsa; Hugh M. Galbraith, M.D., Walker Morledge, M.D., and J. W. Kelso, M.D., Oklahoma City.

The Committee is more and more favorably impressed with the status of cooperation and support which they are now receiving from physicians all over the State in making examinations of Aid to Dependent Children program. Without such assistance, it would of course be impossible for this Committee to perform its function. It was indeed the need for more adequate medical reports and their interpretation that this Committee was established. The measure of improvement in medical reports which we receive is the true indication to the improvement in the section which has been brought about because of this Committee and every physician each time he makes a report still further aids in the accomplishment.

A statistical analysis of the work completed during the period, January 1944, to January, 1945, is herewith submitted.

Cases pending at time of last report 56. Cases referred to the Medical Advisory Committee since last report 1,627. This group is further broken down into the following: New cases 1,359; Reviews 82; Periodic examinations requested by Medical Advisory Committee 161; Appeal cases 13. (1) Pending January 1, 1945, 1. (2) M. A. C. reversed original opinion in 7 of these cases upon receipt of further information. In 3 instances the agency was of the opinion that the applicant had definitely limited capacity. (3) Request withdrawn 1. (4) Applicant considered able to engage in normal occupation 1; Cases resubmitted by counties for further consideration 12.

Total cases studied by the Medical Advisory Committee during this calendar year 1,683. Cases disposed of since last report 1,520. Cases reviewed by M. A. C. 1,492. (1) Disabled for any gainful employment, or to extent employment possibilities are limited 1,349. (a) Concurred with county recommendation 1,308, (b) Did not concur with county recommendation 41. (2) Able to en-

gage in any normal occupation 143. (a) Concurred with county recommendation 115, (b) Did not concur with county recommendation 28. Cases disposed of for other reasons 28. Cases pending as of January 1, 1945, 163.

Families receiving Aid to Dependent Children on the basis of physical or mental incapacity of parent as of January 1, 1945, 3,649.

During the past year, 379 physicians participated in making examinations for the Department, the physicians' fees being paid amounting to \$3,805.50.

Respectfully submitted,

Clinton Gallaher, M.D., Shawnee
Mack I. Shanholtz, M.D.
R. M. Shepard, M.D.
Hugh M. Galbraith, M.D.
Walker Morledge, M.D.
J. W. Kelso, M.D.

REPORT OF MEDICAL ADVISORY COMMITTEE TO THE VOCATIONAL REHABILITATION DIVISION OF THE STATE BOARD OF EDUCATION

The Medical Advisory Committee submits the following report to the House of Delegates:

The Medical Advisory Committee to the physical restoration program of the Vocational Rehabilitation Division was appointed in July, 1944, and has been functioning since that time. Members were suggested by the State Medical Association, State Dental Society, and State Hospital Association, and confirmed by the State Board of Education under which the program operates. They are as follows: Clinton Gallaher, M.D., Chairman, Shawnee; Bert F. Keltz, M.D., Oklahoma City; R. L. Loy, Oklahoma City; Fred O. Pitney, D.D.S., Oklahoma City; James Asher, M.D., Clinton; Ennis Gullatt, M.D., Ada; John C. Perry, M.D., Tulsa. The Committee has met four times: August 5, September 3, October 29, and December 3.

The Vocational Rehabilitation Division has been operating in Oklahoma since 1925 when it accepted the offer of the Federal government to participate in funds set aside for states that would set up within the State Department of Education a division offering vocational guidance, counseling, and training to persons with occupational handicaps. The program is based on the applicant's need to be helped in finding an occupation he can do satisfactorily with his particular physical disability.

In 1943, the program was extended to offer medical and surgical care should there be a reasonable certainty that such care will result in removal or reduction of the occupational handicap. The client must be unable to finance a treatment plan suggested for him. Any condition treated must be static, chronic, and must not require more than 90 days hospitalization. Care in a convalescent home and home nursing may be given if the attending physician thinks it indicated.

In developing a medical program, the Division realized the need for guidance from the medical profession. The purpose of the committee is to advise the State Board of Education in the development of policies and procedures to be followed in administering a public supported program of medical care. This will include types of cases to be handled, fees to be paid to doctors and hospitals, and standards to be met by persons and institutions participating in the program. The Committee will also interpret the vocational rehabilitation program to the medical profession within the State to promote proper understanding of its purpose and methods of operation. It will advise the State Board of Education regarding conditions, policies and practices in the medical profession which might affect the operation of the program.

Policies that have been advised and have been put into effect to date are as follows: The family doctor or one in the local community is to be used as far as possible. The relationship between doctor and patient is to

be encouraged and maintained. Clients may be referred for general examination to any physician practicing in Oklahoma who is licensed by the State Board of Medical Examiners. A general examination is to include blood serology, urinalysis, and blood pressure, and a fee of \$5.00 will be paid for this service. Further diagnostic procedures as x-rays, laboratory work, and consultations may be requested by the examining physician and will be paid for according to the fee schedule suggested by physicians all over the state and approved by the advisory committee. Clients needing treatment may be referred to the doctors of their choice as long as they meet the standards set by the committee. Physicians and surgeons approved to offer medical or surgical treatment are those who are members of the various American specialty boards. The Committee will take steps to expand the panel when it is demonstrated that the number of doctors practicing in the state who are members of these boards are insufficient to meet the need, or when other physicians of equal competence are not readily available and willing. Patients may be hospitalized only in hospitals approved by the American College of Surgeons.

This is a program that must have the understanding and cooperation of the medical profession if it is to reach and serve the vocationally handicapped in Oklahoma. The Division will welcome suggestions from you and will work with you on any cases you wish to refer.

The Advisory Committee earnestly solicits the participation and the suggestions of every member of the Oklahoma State Medical Association, fully realizing that a mutual satisfactory arrangement between the patient and the physician must be the ultimate aim of all policies and customs.

Respectfully submitted,

Clinton Gallaher, M.D., Chairman

Bert F. Keltz, M.D.
James O. Asher, M.D.
Ennis Gullatt, M.D.
John C. Perry, M.D.
Fred O. Pitney, D.D.S.
R. L. Loy.

REPORT OF COMMITTEE ON MEDICAL ECONOMICS

The Committee on Medical Economics submits the following report to the House of Delegates:

In May of 1944, this Committee through its Chairman made contact with representatives of the Farm Security Administration from Oklahoma and Texas. This representation consisted of F. A. Boutwell, Regional Health Specialist, and David N. Etheridge, Associate Health Service Specialist.

These gentlemen explained in detail the methods by which the Farm Security Administration operated in the 23 counties of this state which are organized for the medical care of indigent farmers and their families. Approximately 90 per cent of the participants are tenant farmers unable to obtain loans through the usual sources. In each of these counties, the Blue Cross Hospitalization Plan is in effect in addition to the Medical Service. Creek County was given as an illustration of the practical working of the plan. In this county in 1943 there were 286 participants, all bills were paid 100 per cent of claims and there was a surplus of \$2,700.00. The plan is administered by a committee made up of representatives of the indigent group and three doctors appointed from the County Medical Society. The committee reviews, accepts or rejects all bills submitted. There

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is no adherence to a fee schedule but fees are held within the limits of what the charge would be for individuals in similar circumstances. It was reported that 90 per cent of the counties participating are paying claims 100 per cent and have a surplus.

This plan or any plan will not operate without certain abuses; these abuses lie with the participants as well as the doctors. One of the most common abuses on the part of the doctors is to charge an office call as a result of a street corner conversation.

It will be noted that the representatives of the Farm Security Administration were very enthusiastic about this plan and, naturally, would emphasize its advantages. From personal reports received from different parts of the states participating, it was observed that the doctors do not share their enthusiasm and cannot endorse certain statements.

In view of the fact that a surgical and obstetrical plan has already been adopted by the House of Delegates, it is felt that this particular effort on the part of the Committee has already lost a great part of its potential value.

This Committee wishes to report further on its activities in connection with the economic rehabilitation of physicians returning from the present world conflict. In this respect, your Chairman has worked with others in planning for the post-war medical education of all returning physicians desiring such an opportunity. Definite progress has been made along this line to the point of a schedule of work now in the hands of the committee of the State Medical Association and the State Medical School.

Respectfully submitted,

L. J. Starry, M.D., Chairman
Earl M. Woodson, M.D.
W. C. McCurdy, Jr., M.D.

REPORT OF COMMITTEE ON PUBLIC HEALTH

The Committee on Public Health submits the following report to the House of Delegates:

The work of this Committee has been primarily that of preparing a bill providing for the creation of a State Board of Health and of informing members of the State Medical Association the purposes of such legislation. Dr. Harry S. Mustard, Professor of Public Health Administration and Director of the DeLamar Institute of Public Health, Columbia University, who was one of the guest speakers at the Annual Meeting in Tulsa in 1944 was asked by the Council to appear before them and summarize for them data on Board of Health in the United States. This he did, and a committee was appointed to draw up a resolution recommending that the House of Delegates approve a plan for the appointment of a State Board of Health by the Governor and that the Committee on Public Policy be instructed to present the designated plan to the Governor in time for it to receive legislative consideration at the next session of the State Legislature. This resolution was drawn and approved by the House of Delegates.

In the early summer, a joint meeting of the Public Health Committee and the Public Policy Committee was called to consider plans for legislation which would provide for a Board of Health. The Public Health Committee was instructed to work with the Executive Secretary of the State Association and the Attorney for the Association in the preparation of a bill to be introduced when the Legislature convened in January, 1945. A bill was drawn which provided for a Board of seven members with staggered terms. Members were to be appointed by the Governor to serve a term of seven years each. The Board was to appoint the Commissioner of Health, make rules and regulations and be policy forming.

This bill was presented to the Council as a committee report at a meeting in October, 1944. This group recom-

mended it for approval by the House of Delegates which they did in a meeting in the afternoon of the same day.

Following this, the Chairman of the Public Health Committee with representatives from the Public Policy Committee presented the bill to Councilor District meetings in the ten Districts. The content of the bill was gone over and questions answered as they arose in regard to it.

This bill was presented by the Public Policy Committee and the President of the State Association to the Governor in December. He accepted it in principle and in his message to the Legislature in January he made definite recommendations that legislation providing for a State Board of Health be passed.

At the time of this writing, the bill has been introduced and passed by the House of Representatives with some amendments, namely that of creating a board of eight instead of seven members with the designation that one member should come from each Congressional District and the Commissioner of Health shall be allowed to vote in case of a tie. Another amendment provided that a chiropractor and an osteopath should be included on the board. An effort is being made to eliminate both the chiropractor and osteopath at this time.

Respectfully submitted,

John W. Shackelford, M.D., Chairman
C. C. Young, M.D.
Phillip G. Joseph, M.D.

REPORT OF COMMITTEE ON SCIENTIFIC WORK

The Committee on Scientific Work submits the following report to the House of Delegates:

Your Committee on Scientific Work desires to report that its activities did not materialize with reference to the 53rd Annual Meeting in view of the order received from the Office of Defense Transportation that all conventions and meetings with attendance of more than 50 be cancelled if scheduled to meet after February 1.

All spaces in the exhibit hall had been sold to commercial houses. Guest Speakers had been secured for most of the Scientific Sections, and the programs for several sectional meetings completed.

The Committee urges that those physicians who have unpublished scientific papers submit them to the Editorial Board of the Journal of the Association for approval for publication.

Respectfully submitted,

J. H. Robinson, M.D., Chairman
W. A. Showman, M.D.
Ben H. Nicholson, M.D.

REPORT OF COMMITTEE ON NECROLOGY

The Committee on Necrology submits the following report to the House of Delegates:

We deeply regret the necessity of dispensing with the Annual Meeting of the Oklahoma State Medical Association this year.

Due to the greater number of our members being called to the colors, the strain has been greater on those left at home making the death toll greater on both the home and the fighting front than last year. We know that many physicians who have died in private practice during the past year have as surely died in the service of their country as have those who died on the battlefield since some physicians returned to active practice from retirement to help care for the sick who would otherwise have been neglected due to the scarcity of doctors. Also, many who should have retired from practice due to age did not but continued to practice, not from a monetary standpoint but from a humanitarian one, thereby probably shortening their lives.

That those members who have paid the supreme sacrifice in either civilian or military service may be accorded the honor due them, the Committee on Necrology submits the following resolutions for adoption by the House of Delegates:

WHEREAS, Since the 1944 report made by the Committee on Necrology of the Association, the Grim Reaper has gathered 26 of our members,

THEREFORE, BE IT RESOLVED, That the House of Delegates of the Oklahoma State Medical Association give due recognition to the demise of the said 26 fellow members and to the honor we hold for them as well as our deep regret at the parting, and instruct the Secretary to inscribe their names upon the records of the Association as follows:

*J. H. Harms	Cordell	Nov. 25, 1943
Frank M. King (Army)	Woodward	Jan. 10, 1944
John E. Crawford	Bartlesville	Mar. 19, 1944
Charles H. Hale	Boswell	Apr. 25, 1944
*G. P. Cherry	Mangum	May 14, 1944
Ralph O. Early	Okla. City	June 6, 1944
Bernard Bullock (Army)	Clinton	June 10, 1944
John R. Pollock	Ardmore	June 28, 1944
James G. Rafter	Muskogee	June 30, 1944
J. B. Gilbert	Tulsa	July 6, 1944
Hugh R. Shannon	Pond Creek	July 9, 1944
W. J. Mason	Lawton	July 13, 1944
Ned R. Smith	Tulsa	Aug. 18, 1944
Roy E. Baze (Army)	Chickasha	Aug. 24, 1944

*Thomas M. Aderhold	El Reno	Sept. 7, 1944
Cephas J. Wells	Bartlesville	Sept. 9, 1944
W. B. Carroll	Norman	Sept. 9, 1944
M. M. DeArman	Miami	Nov. 4, 1944
David W. Connally	Antlers	Nov. 8, 1944
N. A. Jones	Okla. City	Nov. 18, 1944
J. I. Hollingsworth	Waurika	Nov. 30, 1944
W. T. Huddleston	Konawa	Nov. 30, 1944
J. E. Heiss	Perry	Dec. 14, 1944
John A. Walker	Shawnee	Dec. 25, 1944
L. D. Gillespie	Ardmore	Jan. 4, 1945
William P. Greening	Pauls Valley	Mar. 2, 1945

*Honorary

Respectfully submitted,

H. A. Higgins, M.D., Chairman

O. G. Bacon, M.D.

R. H. Sherrill, M.D.

REPORT OF COMMITTEE ON STUDY AND CONTROL OF TUBERCULOSIS

The Committee on the Study and Control of Tuberculosis submits the following report to the House of Delegates:

According to a report in the British Medical Journal, December 4, 1943, the mass of evidence testifying to the immunizing power of BCG in animals is very promising. Still more effective is a living vaccine made from Wells'

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vole tubercle bacillus, judging by the few experiments before the war of Wells in guinea pigs and of Griffith and Dalling in calves. The degree of resistance in these experiments was striking, amounting in calves almost to full immunity and encouraging the liveliest hopes for the future of this method. Apart from apparent greater efficacy, the vole bacillus vaccine has the important advantage that the bacillus is not a natural parasite of man and cattle. Its virulence need not be artificially reduced and there is no danger of increased pathogenicity or of such diminution as to reduce its immunizing power; it need only be maintained in its natural host to preserve its existing properties.

In regard to human vaccination, first-hand accounts of what is being done in Norway, Canada and the United States were presented at a meeting of the Tuberculosis Association in London in November, 1943. The voluntary immunization of tuberculin-negative Norwegian nurses with BCG was begun in 1926. Among the vaccinated, the annual incidence of tuberculosis has been 2.6 per cent and the mortality rate from it 0.2 per cent; the corresponding figures for other nurses, nonvaccinated and tuberculin-negative on entry, are 17.6 and 1.8 per cent. Among vaccinated tuberculin-negative medical students, the incidence of tuberculosis has been 1.2 per cent as against 4.3 per cent among the nonvaccinated controls. In Saskatchewan, Canada, where tuberculosis among the Indians is 10 times as common as in the European population, Indian babies born in alterante years are immunized with BCG, using the others as controls. Immunization is also available to all tuberculin-negative nurses, among whom, as in Norway, tuberculosis has in the past been unduly frequent. The results of these efforts as far as they can be assessed, are satisfactory.

Wells has given vole bacillus vaccine to three human volunteers who became tuberculin-positive; the only ill effect was a local abscess in one given probably an excessive dose.

Brooke and Day in the Bulletin of Johns Hopkins Hospital, May, 1944, concluded from experimental study in guinea pigs that the D 15 strain of the Vole Acid Fast Bacillus significantly delayed the onset and diminished the severity of infection with the human type of tubercle bacillus.

The results of a study made at the University of Pennsylvania show that ultra-violet irradiation of the air of a room exercises a protective influence against natural air-borne contagion of tuberculosis in rabbits. Radiant energy of low intensity reduces the incidence of tuberculosis considerably. It completely protects rabbits of high natural resistance from acquiring demonstrable disease, although they become tuberculin-sensitive. It fails to protect a small proportion of rabbits of low natural resistance from fatal tuberculosis. When the radiant energy is of high intensity, all rabbits, whether of high or low natural resistance, are almost completely protected from contagion so severe that it is fatal to most rabbits of the same genetic constitution not protected by these rays. The protected rabbits do not develop tuberculin-sensitivity. The contagion of tuberculosis in these studies was air-borne and the radiant energy exercised its protective influence by its bactericidal properties. Ultra-violet radiation may control air-borne contagion of human tuberculosis.

Administration of the sulfone drugs (Promizole, Promin and Diasone) in the treatment of tuberculosis has not been too promising in humans. Experiments indicate that Diasone is the most toxic of these drugs.

Eudative lesions of recent origin appear to be more promising for chemotherapy than those which involve caseation, necrosis, cavitation and fibrosis.

The Committee on Therapy of the American Trudeau Society published a statement (American Review of Tuberculosis 49:391-392, April, 1944) emphasizing that the curative value of these drugs in tuberculosis in human beings cannot be estimated even tentatively on the data so far made available. The studies are still in the investigative stage, and human beings have not been found to respond in the same way as guinea pigs.

The conclusions reached by Hinshaw and Feldman (Mayo Clinic) and Pfeutze (Cannon Falls, Minnesota) seems to epitomize the condition as it exists at the present time in regard to these drugs. "Clinical results cannot be evaluated at this period of study. The trend toward spontaneous healing is frequently observed; furthermore healing mechanisms in tuberculosis act slowly and are unlike those noted in acute diseases responding to chemotherapy. There is also no quantitative measure of activity of lesions, such as serologic tests afford in syphilis. Accurately controlled studies will be required before this or any other therapeutic agent can be evaluated in pulmonary tuberculosis, and patients should be offered no hope of immediate prospects of simplified therapy."

The importance of early diagnosis, the management of cases by a trained phthisiologist and the institution of the accepted and proven measures of collapse therapy is our main sheet anchor in the control and rehabilitation of the tuberculosis patient. It is observed that the public, as a whole, is now demanding earlier diagnosis and adequate treatment for tuberculosis patients, and it is the consensus of opinion of the Committee that the phthisiologists and state institutions should be given funds to meet their demands.

More beds in the state sanatoria at Clinton and Tahmina, additional medical and other personnel for whom an adequate salary should be provided, wholesome food and well-balanced diets prepared under the direction of competent dietitians and the elimination of political interference are features which should be given serious consideration. Naturally the war has necessitated serious handicaps.

The facilities for caring for tuberculous patients must be brought up to date, and the Health Department of the State should be better equipped to investigate and advise people in the various parts of the state about tuberculosis. Very few counties have an active, intelligent tuberculosis program. Due to present conditions, it is impossible because of the lack of trained help such as doctors and graduate nurses to do the necessary contact work at this time since it is an impossibility to even secure enough personnel to properly handle patients in the sanatoria.

Tuberculosis will no doubt be on the increase. Ex-service men, coming home from the war, will have to be hospitalized. Even if the Government does hospitalize them, the people they contact will have to be cared for.

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Original illustration
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Practice of Obstetric
Medicine, by D. D. Davis,
M.D., London, 1836.

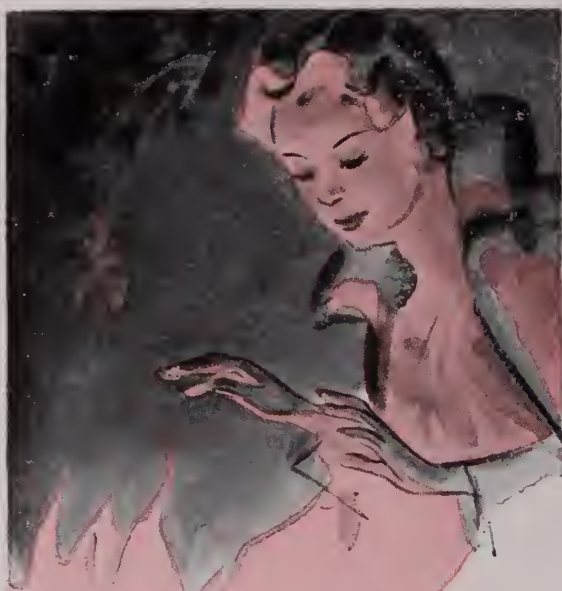
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There should be funds available, particularly for the smaller communities, to x-ray tuberculosis contacts and those with symptoms of tuberculosis.

It is the belief of the Committee that all interested agencies in the care and control of tuberculosis should take immediate and necessary steps to initiate a program of this type through the State Health Department and offers its services to that end.

It is hoped that in the near future a more simple solution will be found to control and cure this disease which still ranks first as the cause of death in individuals between the ages of 15 and 45, the prime of life and usually the most productive years.

Respectfully submitted,

Floyd Moorman, M.D., Chairman

F. P. Baker, M.D.

R. M. Shepard, M.D.

REPORT OF THE COMMITTEE ON POSTGRADUATE MEDICAL TEACHING

The Committee on Postgraduate Medical Teaching submits the following report to the House of Delegates:

The postgraduate program in surgical diagnosis conducted by A. G. Fletcher, M.D., F.A.C.S., Philadelphia, Pennsylvania, has been given in three circuits, including the centers of Miami, Vinita, Bartlesville, Claremore, Pryor, Ada, Durant, Hugo, Idabel, Sulphur, McAlester, Poteau, Okmulgee, Tahlequah and Muskogee.

A total of 279 physicians were enrolled and lecture manuals were distributed to all. One hundred thirty-six Certificates of Attendance were issued to those whose attendance averaged 70 per cent or more. Doctor Fletcher held 100 private consultations with physicians.

The course in surgical diagnosis was discontinued October 1, and as yet a competent instructor has not been procured to continue the succeeding courses. Every attempt is still being made to obtain an instructor of whom we may be justly proud.

The Committee desires to thank The Commonwealth Fund of New York, the Oklahoma State Health Department, the United States Public Health, and the Oklahoma State Medical Association for their financial assistance, and further recommends that the House of Delegates, by resolution, express its appreciation to these contributing agencies.

Respectfully submitted,

Gregory E. Stanbro, M.D., Chairman

Wann Langston, M.D.

H. M. McClure, M.D.

J. C. Matheney, M.D.

H. B. Stewart, M.D.

H. C. Weber, M.D.

REPORT OF MEDICAL ADVISORY COMMITTEE TO THE OKLAHOMA VETERANS' ASSISTANCE PROGRAM

The Medical Advisory Committee to the Oklahoma Veterans' Assistance Program submits the following report to the House of Delegates:

At the request of Honorable Milt Phillips, Director of the Oklahoma Veterans' Assistance Program, Dr. C. R. Rountree appointed a committee to serve in an advisory capacity with regard to psychiatric problems.

The Committee met in the Blue Room of the Governor's office on January 3, 1945, and discussed the problems. Many suggestions were proposed.

It was pointed out that practically all of the neurosis cases were constant applicants before the Veterans' Employment Service in the United States Employment Offices. It was agreed that psychiatrists of the State Medical Association would tender their services to the Veteran Employment Service for lectures as the Veteran Employment Representatives of the various offices were called into the conferences in Oklahoma City by the United States Employment Service Officials. Phillips agreed to take this matter up with the present War Manpower Commission Director, in whose division the

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Vitamin D.....1,000 U.S.P. Units

Vitamin B₁.....666 U.S.P. Units
Vitamin C.....50 mg., 1,000 U.S.P. Units
Vitamin E.....Alpha Tocopherol, 1 mg.
Vitamin G (B₂).....2 milligrams
Vitamin B₆.....50 micrograms
Niacinamide.....20 milligrams
Calcium Pantothenate.....1 milligram
Liver Concentrate (1:20).....2 grains
Ferrous Sulfate.....1 grain

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United States Employment Service and the Veterans' Employment Service now operate, and request time be devoted to this subject on the next monthly conference of Veteran Employment Representatives.

In discussing the ultimate problem with the mild neurosis cases, it was agreed that regular types of institutions, such as operated by the Veterans' Administration and the State hospitals would be of very little benefit to these men. It was agreed that a "colony" type of treatment centers, similar to the present Army Rehabilitation Centers, were necessary. The committee recommended that the State urge, at the earliest possible moment, that the Federal Government begin establishing such facilities in each state or region so that the men would not be sent too far from their homes for treatment. Phillips agreed to present this matter to the Oklahoma Soldiers' Relief Commission, then, after a conference with the Governor, to present the matter to Federal Officials if the Commission and the Governor approved.

Respectfully submitted,

John L. Day, M.D.
D. W. Griffin, M.D.
C. E. Leonard, M.D.
F. M. Adams, M.D.
Coyne Campbell, M.D.
Major M. P. Prosser.

COMMITTEE ON STUDY AND CONTROL OF VENEREAL DISEASES

The Committee on the Study and Control of Venereal Diseases submits the following report to the House of Delegates:

In 1944, the Venereal Disease Division of the Oklahoma State Health Department functioned along lines generally accepted in public health practice throughout the nation. A total of 71 public venereal disease clinics were active in the state, and there was a marked reduction in their population due principally to the improved economic status of the majority of persons which has enabled them to pay private physicians for treatment.

In connection with the public health clinics, the Division of Venereal Disease employs 26 investigators whose duties are to do case finding through contact tracing, and case holding of infectious patients who have not received enough treatment to render them permanently non-infectious. The services of these investigators are available on request to any private physician for purposes of bringing delinquent patients to treatment or for persuading contacts of infectious patients to be examined.

Though the following figures show a predominance of patients reported by public clinics, it must be borne in mind that clinic directors are required to report all cases diagnosed while it is generally conceded that private physicians as a whole report only a fraction of the cases which they have under treatment. It is important, too, to take into consideration the fact that all clinic cases reported are merely new admissions and may have been referred to a private physician for treatment. This step serves to give credit to the clinic for finding the case and places the responsibility on the clinic of checking to see that the patient actually reported to the private physician for treatment.

The following is a break-down of venereal disease cases reported in Oklahoma during 1944: PRIVATE PHYSICIANS—Syphilis 3,369, Gonorrhea 1,268, Other

V. D. 11; PUBLIC CLINIC—Syphilis 4,342, Gonorrhea 5,402, Other V. D. 27.

A general discussion of proposed venereal disease legislation was followed by a recommendation of the committee for a premarital, prenatal and a venereal disease quarantine law. The committee felt the need for a legal definition of syphilis, gonorrhea and other venereal disease as being contagious and infectious and authorization of quarantine when necessary was acute.

Respectfully submitted,

Alfred R. Sugg, M.D., Chairman
C. B. Taylor, M.D.
W. F. Lewis, M.D.

REPORT OF COMMITTEE ON JUDICIAL AND PROFESSIONAL RELATIONS

The Committee on Judicial and Professional Relations submits the following report to the House of Delegates:

Your Committee on Judicial and Professional Relations desires to report that during 1944-1945 there have been no requests made for assistance from the Medical Defense Fund. As of March 1, there was on deposit in the Medical Defense Fund \$619.34 as shown in the audit report of the Association.

Respectfully submitted,

E. H. Shuller, M.D., Chairman
S. A. Lang, M.D.
Claude S. Chambers, M.D.

REPORT OF ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

The advisory Committee to the Woman's Auxiliary submits the following report to the House of Delegates:

Your Committee desires to report that it has had no occasion to meet during the past year. The officers of the Woman's Medical Auxiliary requested no advice or assistance, consequently the Committee has been inactive.

Respectfully submitted,

E. Eugene Rice, M.D., Chairman
F. Maxey Cooper, M.D.
Hugh Perry, M.D.
W. T. Mayfield, M.D.
A. R. Sugg, M.D.

HONORARY MEMBERSHIP APPLICATIONS

The following names have been submitted to the Executive Office of the Association for election to Honorary Membership in accordance with the provisions of Chapter I, Section 3, Subsection (b), of the By-Laws:

P. L. McClure, Fort Cobb.
Ralph V. Smith, Pryor.
Floyd E. Watterfield, Muskogee.

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A private hospital for the diagnosis, study and treatment of all types of neurological and psychiatric cases. Equipped to give all forms of recognized therapy, including hyperpyrexia, insulin and metrazol treatments, when indicated. Consultation by appointment.

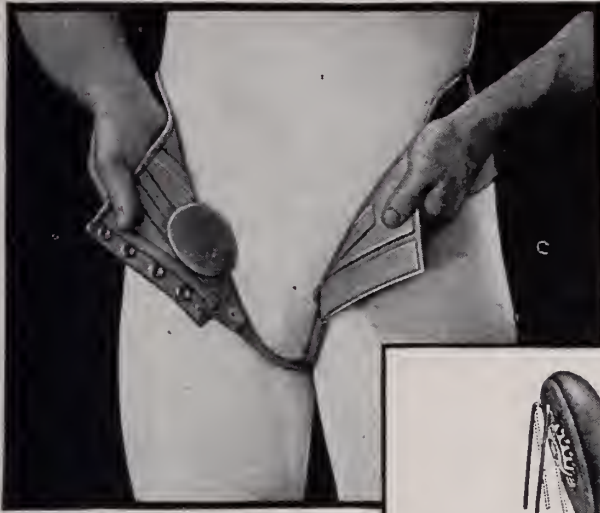
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The CAMP adjustable spring pad for use with the belt is equipped with prongs of piano wire. The strong flexible prongs fit firmly in the casings of the belt. Pads are available in varying shapes and depths.

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Surgeons who wish some protection over the area after operation will find this belt of particular advantage because the adjustment allows varying degrees of firmness about the lower abdomen.

DELEGATES AND ALTERNATES

In compliance with the By-Laws of the Oklahoma State Medical Association, the following listed delegates and alternates have been certified to the Executive Office as representatives of their respective counties at the Annual Meeting.

Credential cards have been mailed to the delegates and alternates, who in turn must present their credentials to the Credentials Committee prior to the first meeting of the House of Delegates on Monday evening, April 24.

<i>County</i>	<i>Delegate</i>	<i>Alternate</i>
Alfalfa.....	Forrest Hale, Cherokee	
Atoka-Coal.....	J. S. Fulton, Atoka	W. W. Cotton, Atoka
	J. J. Hipes, Coalgate	J. B. Clark, Coalgate
Beckham.....	G. H. Stagner, Erick	O. C. Standifer, Elk City
Blaine.....	L. R. Kirby, Okeene	D. F. Stough, Jr., Geary
Bryan.....	O. J. Colwick, Durant	John A. Haynie, Durant
Caddo.....	C. B. Sullivan, Carnegie	P. H. Anderson, Anadarko
Canadian.....	J. T. Phelps, El Reno	M. E. Phelps, El Reno
Carter.....	C. A. Johnson, Ardmore	F. W. Boadway, Ardmore
	Walter Hardy, Ardmore	Walter Johnson, Ardmore
Cherokee.....	H. A. Masters, Tahlequah	William M. Wood, Tahlequah
Choctaw.....		
Cleveland.....	Iva S. Merritt, Norman	O. M. Woodson, Norman
	F. T. Gastineau, Norman	M. M. Wickham, Norman
Comanche.....		
Cotton.....	G. W. Baker, Walters	Mollie F. Seism, Walters
Craig.....	F. M. Adams, Vinita	W. R. Marks, Vinita
Creek.....	J. B. Lampton, Sapulpa	J. E. Hollis, Bristow
Custer.....	McLain Rogers, Clinton	Ellis Lamb, Clinton
	E. M. Loyd, Taloga	C. Doler, Clinton
Garfield.....	V. R. Hamble, Enid	
	Julian Feild, Enid	
Garvin.....	Morton E. Robberson, Wynnewood	Galvin L. Johnson, Pauls Valley
Grady.....	Walter J. Baze, Chickasha	H. M. McClure, Chickasha
Greer.....	J. B. Hollis, Mangum	J. T. Lowe, Mangum
Harmon.....	W. G. Husband, Hollis	R. H. Lynch, Hollis
Haskell.....	J. C. Rumley, Stigler	W. A. Thompson, Stigler
Hughes.....	W. E. Floyd, Holdenville	
	E. S. Crow, Olustee	
Jackson.....		J. P. Irby, Altus
Jefferson.....		
Kay.....	Dewey Mathews, Tonkawa	I. D. Walker, Tonkawa
	G. H. Yeary, Newkirk	A. S. Nuckols, Ponca City
Kingfisher.....		
Kiowa.....	J. M. Bonham, Hobart	A. H. Hathaway, Mountain View
LeFlore.....	F. P. Baker, Tahlequah	
Lincoln.....	Ned Burleson, Prague	Carl H. Bailey, Stroud
Logan.....	L. A. Hahn, Guthrie	
Marshall.....		
Mayes.....	Carl Puckett, Oklahoma City	Ralph V. Smith, Pryor
McClain.....	R. L. Royster, Purcell	S. C. Davis, Blanchard
McCurtain.....	W. W. Williams, Idabel	R. B. Oliver, Idabel
McIntosh.....		
Muskogee-Sequoyah-Wagoner.....	C. E. White, Muskogee	E. Halsell Fite, Muskogee
	L. S. McAlister, Muskogee	John R. Rafter, Muskogee
	John A. Morrow, Sallisaw	W. H. Newlin, Sallisaw
	H. K. Riddle, Coweta	J. H. Plunkett, Wagoner

Noble.....	T. F. Renfrow, Billings	J. W. Driver, Perry
Okfuskee.....	A. S. Melton, Okemah	M. L. Whitney, Okemah
Oklahoma.....	L. Chester McHenry, Oklahoma City	Oscar White, Oklahoma City
	W. Floyd Keller, Oklahoma City	Ben H. Nicholson, Oklahoma City
	R. Q. Goodwin, Oklahoma City	L. J. Starry, Oklahoma City
	R. H. Akin, Oklahoma City	Elmer R. Musick, Oklahoma City
	C. M. Pounders, Oklahoma City	H. L. Deupree, Oklahoma City
	D. H. O'Donoghue, Oklahoma City	F. M. Lingenfelter, Oklahoma City
	W. E. Eastland, Oklahoma City	W. K. West, Oklahoma City
	Walker Morledge, Oklahoma City	Harper Wright, Oklahoma City
	C. M. O'Leary, Oklahoma City	O. Alton Watson, Oklahoma City
	John F. Burton, Oklahoma City	M. F. Jacobs, Oklahoma City
	John H. Lamb, Oklahoma City	J. B. Eskridge, Jr., Oklahoma City
	James R. Reed, Oklahoma City	G. E. Stanbro, Oklahoma City
Okmulgee.....	J. C. Matheny, Okmulgee	W. M. Haynes, Henryetta
	J. G. Edwards, Okmulgee	H. D. Boswell, Henryetta
Osage.....	Roscoe Walker, Pawhuska	G. I. Walker, Hominy
Ottawa.....	P. J. Cunningham, Miami	J. W. Craig, Miami
	L. P. Hetherington, Miami	J. P. Hampton, Miami
Payne.....	H. C. Manning, Cushing	F. Keith Ochlschlager, Yale
Pittsburg.....	L. S. Willour, McAlester	E. H. Shuller, McAlester
	T. H. McCarley, McAlester	F. J. Baum, McAlester
Pontotoc-Murray.....	Alfred R. Sugg, Ada	Wilson H. Lane, Ada
	O. H. Miller, Ada	M. M. Webster, Ada
	W. P. Rudell, Sulphur	
Pottawatomie.....	W. M. Gallaher, Shawnee	C. C. Young, Shawnee
	E. Eugene Rice, Shawnee	G. S. Baxter, Shawnee
Pushmataha.....	E. S. Patterson, Antlers	J. S. Lawson, Clayton
Rogers.....	R. C. Meloy, Claremore	Clyde W. Beson, Claremore
Seminole.....	Claude S. Chambers, Seminole	L. R. Pace, Seminole
Stephens.....		
Texas.....		
Tillman.....	J. D. Osborn, Frederick	J. E. Arrington, Frederick
Tulsa.....	W. A. Showman, Tulsa	Morris B. Lhevine, Tulsa
	H. B. Stewart, Tulsa	Hugh J. Evans, Tulsa
	Ralph A. McGill, Tulsa	Carl F. Simpson, Tulsa
	M. V. Stanley, Tulsa	David V. Hudson, Tulsa
	Marvin D. Henley, Tulsa	W. A. Walker, Tulsa
	John C. Perry, Tulsa	W. A. Dean, Tulsa
	W. S. Larrabee, Tulsa	M. O. Hart, Tulsa
	H. A. Ruprecht, Tulsa	James D. Markland, Tulsa
	L. C. Northrup, Tulsa	D. W. LeMaster, Tulsa
Washington-Nowata.....	L. D. Hudson, Dewey	H. C. Weber, Bartlesville
	O. I. Green, Bartlesville	H. G. Crawford, Bartlesville
	K. D. Davis, Nowata	S. A. Lang, Nowata
Washita.....	A. H. Bungardt, Cordell	A. S. Neal, Cordell
Woods.....	D. B. Ensor, Hopeton	Wm. F. LaFon, Waynoka
Woodward.....	J. L. Day, Supply	D. W. Darwin, Woodward
	O. C. Newman, Shattuck	Roy Newman, Shattuck
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Annual Audit Report

February 22, 1945

Charles R. Rountree, M.D., President
Oklahoma State Medical Association
210 Plaza Court
Oklahoma City, Oklahoma

Dear Sir:

We have completed the audit of the financial records of:

THE OKLAHOMA STATE MEDICAL ASSOCIATION

OKLAHOMA CITY, OKLAHOMA

for the period from January 1, 1944, to December 31, 1944, and submit herewith the following Exhibits:

EXHIBIT "1"—Balance Sheet

EXHIBIT "2"—Statement of Cash Receipts and Disbursements

EXHIBIT "3"—Operating Statement

EXHIBIT "4"—Bank Reconciliation

We wish to thank you for this audit, and if we can be of further service, please feel free to call upon us.

Respectfully Submitted,

H. E. COLE COMPANY

By H. E. Cole

OKLAHOMA STATE MEDICAL ASSOCIATION

Oklahoma City, Oklahoma

EXHIBIT "1"

BALANCE SHEET

December 31, 1944

ASSETS	Total	Membership Fund	Journal Fund	Medical Defense Fund	Annual Meeting	State Fair Fund
Petty Cash	\$ 11.09	\$ 11.09	\$.....	\$.....	\$.....	\$.....
Bank	11,407.49	9,433.51	846.17	619.34	446.60	61.87
U. S. Defense Bonds	3,220.00	3,220.00	.....	.....	.....	.....
U. S. Treasury Bonds	6,178.88	6,178.88	.....	.....	.....	.....
U. S. Savings Bonds	1,000.00	1,000.00	.....	.....	.....	.....
TOTAL ASSETS	\$21,817.46	\$19,843.48	\$ 846.17	\$ 619.34	\$ 446.60	\$ 61.87
LIABILITIES						
Operating Reserve	\$21,817.46	\$19,843.48	\$ 846.17	\$ 619.34	\$ 446.60	\$ 61.87
TOTAL LIABILITIES	\$21,817.46	\$19,843.48	\$ 846.17	\$ 619.34	\$ 446.60	\$ 61.87

OKLAHOMA STATE MEDICAL ASSOCIATION

Oklahoma City, Oklahoma

EXHIBIT "2"

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS

January 1, 1944 to December 31, 1944

Cash Balance—January 1, 1944	\$10,316.20	\$ 7,843.55	\$ 1,260.81	\$ 606.84	\$ 605.00	\$
Petty Cash Balance—January 1, 1944	10.69	10.69	.....	.....	.....	.....
Transfer from Membership Fund*	1,000.00	.....	1,000.00	.....	.....	.....

RECEIPTS

Membership Dues — 1944	13,926.00	13,926.00	.....	.....	.....	.....
Journal Advertising and Subscriptions	9,433.86	.....	9,433.86	.....	.....	.....
Government Bond Interest	185.00	172.50	.....	12.50	.....	.....
Sale of Furniture	76.00	76.00	.....	.....	.....	.....
State Fair Income for Exhibit	525.00	.....	.....	.....	.....	525.00
Annual Meeting — 1944	2,032.11	.....	.....	.....	2,032.11	.....
Annual Meeting — 1945	210.00	.....	.....	.....	210.00	.....
Miscellaneous Income	12.00	.....	12.00	.....	.....	.....
Refund — Post Graduate Committee	699.16	699.16	.....	.....	.....	.....
Total Cash to be Accounted for	\$38,426.02	\$22,727.90	\$11,706.67	\$ 619.34	\$ 2,847.11	\$ 525.00

DISBURSEMENTS

Expenses for 1944	\$26,007.44	\$12,283.30	\$10,860.50	\$	\$ 2,400.51	\$ 463.13
Transfers	1,000.00	1,000.00	.....	.....	.....	.....
Bank Balance—December 31, 1944	\$27,007.44	\$13,283.30	\$10,860.50	\$	\$ 2,400.51	\$ 463.13
Petty Cash—December 31, 1944	\$11,407.49	\$ 9,433.51	\$ 846.17	\$ 619.34	\$ 446.60	\$ 61.87
	11.09	11.09	.....	.....	.....	.....
	\$11,418.58	\$ 9,444.60	\$ 846.17	\$ 619.34	\$ 446.60	\$ 61.87

*NOTE—Transfer of \$1,000.00 was made from Membership Fund to Journal Fund to take care of Publication Deficit.

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SURGERY

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intestinal diseasesComplete laboratory and X-ray facilities.
Electrocardiograph.

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Oklahoma City

OKLAHOMA STATE MEDICAL ASSOCIATION

Oklahoma City, Oklahoma

EXHIBIT "3"

OPERATING STATEMENT

1944

	<i>Total</i>	<i>Membership Fund</i>	<i>Journal Fund</i>	<i>Medical Defense Fund</i>	<i>Annual Meeting</i>	<i>State Fair Fund</i>
REVENUES						
Membership Dues—1944	\$13,926.00	\$13,926.00	\$.....	\$.....	\$.....	\$.....
Journal Advertising and Subscriptions	9,433.86	.....	9,433.86	.....	.....	.....
Government Bond Interest	185.00	172.50	.....	12.50	.....	.....
Annual Meeting—1944	2,032.11	.....	.....	.....	2,032.11	.....
Annual Meeting—1945	210.00	.....	.....	.....	210.00	.....
State Fair Exhibit	525.00	.....	.....	.....	.....	525.00
Sale of Furniture	76.00	76.00	.....	.....	.....	.....
Miscellaneous	12.00	.....	12.00	.....	.....	.....
Refund—Post Graduate Committee	699.16	699.16	.....	.....	.....	.....
TOTAL REVENUES	\$27,099.13	\$14,873.66	\$ 9,445.86	\$ 12.50	\$ 2,242.11	\$ 525.00
EXPENSES						
Salaries	\$ 8,869.30	\$ 3,819.30	\$ 5,050.00	\$.....	\$.....	\$.....
Telephone and Telegraph	432.60	432.60	.....	.....	.....	.....
Rent	475.00	225.00	250.00	.....	.....	.....
Postage	678.14	522.84	155.30	.....	.....	.....
Stationery and Printing	386.92	321.12	65.80	.....	.....	.....
Office Supplies	410.08	284.42	125.66	.....	.....	.....
Traveling Expense	600.49	600.49	.....	.....	.....	.....
Journal Printing and Mailing	4,807.63	.....	4,807.63	.....	.....	.....
Journal Engraving	228.75	.....	228.75	.....	.....	.....
Press Clipping Service	66.30	.....	66.30	.....	.....	.....
Expense of Paul Fesler to Oklahoma City about Job	80.92	80.92	.....	.....	.....	.....
Expense of Paul Fesler to Oklahoma City—Moving	200.00	200.00	.....	.....	.....	.....
Auditing and Legal	112.50	37.50	75.00	.....	.....	.....
Express	4.40	4.40	.....	.....	.....	.....
A.M.A. Delegates Travel Expense	370.57	370.57	.....	.....	.....	.....
A.M.A. Regional Conference— Public Relations—Travel	106.78	106.78	.....	.....	.....	.....
Annual Meeting Expense	2,447.81	47.30	.....	.....	2,400.51	.....
Office Furniture and Fixtures	477.36	477.36	.....	.....	.....	.....
Office Equipment Purchased	176.96	176.96	.....	.....	.....	.....
Post Graduate Committee	2,000.00	2,000.00	.....	.....	.....	.....
Council and Committee Luncheons	222.34	222.34	.....	.....	.....	.....
Miscellaneous Expense	38.11	38.11	.....	.....	.....	.....
Remodeling Office	1,722.30	1,722.30	.....	.....	.....	.....
Books and Magazines for Library	97.50	97.50	.....	.....	.....	.....
American Red Cross	25.00	25.00	.....	.....	.....	.....
Reprints "Socialized Medicine"	135.20	135.20	.....	.....	.....	.....
Typewriter Repairs	12.52	12.52	.....	.....	.....	.....
Pictures of Past Presidents	6.63	6.63	.....	.....	.....	.....
Publicity Committee Contribution	175.00	175.00	.....	.....	.....	.....
Surety Bond	56.25	56.25	.....	.....	.....	.....
Rental on Safety Deposit Box	6.00	6.00	.....	.....	.....	.....
Year Book Expense	58.88	22.82	36.06	.....	.....	.....
Chamber of Commerce	25.00	25.00	.....	.....	.....	.....
Fire Insurance	11.54	11.54	.....	.....	.....	.....
Flowers	9.53	9.53	.....	.....	.....	.....
Associate Membership	10.00	10.00	.....	.....	.....	.....
State Fair Exhibit Expense	463.13	.....	.....	.....	.....	463.13
TOTAL EXPENSES	\$26,007.44	\$12,283.30	\$10,860.50	\$.....	\$ 2,400.51	\$ 463.13
REVENUE OVER EXPENSES	\$ 1,091.69	\$ 2,590.36	—\$1,414.64	\$ 12.50	—\$ 158.40	\$ 61.87

OKLAHOMA STATE MEDICAL ASSOCIATION

Oklahoma City, Oklahoma

EXHIBIT "4"

BANK RECONCILIATION

December 31, 1944

LIBERTY NATIONAL BANK

MEMBERSHIP FUND

Balance per Bank Statement		\$ 9,685.73
Outstanding Checks		
Voucher No. 1467 Modern Hospital Pub. Co.	\$ 2.50	
Voucher No. 1480 Postmaster	70.12	
Voucher No. 1481 Survey Association, Inc.	2.00	
Voucher No. 1483 Collector of Internal Revenue	177.60	252.22
		<hr/>
Balance per Books		\$ 9,433.51

JOURNAL FUND

Balance per Bank Statement		\$ 1,257.57
Outstanding Checks		
Voucher No. 1476 Dr. L. J. Moorman	\$ 90.40	
Voucher No. 1477 Jane Firrell Tucker	160.80	
Voucher No. 1484 Collector of Internal Revenue	160.20	411.40
		<hr/>
Balance per Books		\$ 846.17

ANNUAL MEETING FUND

Balance per Bank Statement		\$ 446.60
Balance per Books		\$ 446.60

MEDICAL DEFENSE FUND

Balance per Bank Statement		\$ 619.34
Balance per Books		\$ 619.34

STATE FAIR FUND

Balance per Bank Statement		\$ 61.87
Balance per Books		\$ 61.87
TOTAL MONEY ON DEPOSIT		\$11,407.49

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MEDICAL ABSTRACTS

HISTOPATHOLOGY OF THE NASAL MUCOSA OF OLDER PERSONS. A. R. Hollender. Archives of Otolaryngology, Vol. 40, pp. 92-100, August, 1944.

The author's purpose is to describe the influence of aging on the nasal mucosa. He examined the nose, especially the interior turbinates, of 23 cadavers of persons between 50 and 90 years of age.

All types of epithelium were seen, but no definite relation could be established between the age of the subject and the type of epithelium. As usual, the basement membrane presented different thicknesses even in the same specimen. In younger persons the subepithelial layer is characterized by accumulation of leukocytes, which occasionally may form follicles. In the specimens studied diffuse accumulation of leukocytes in the subepithelial layer was seldom seen. The leukocytes consisted of lymphocytes and plasma cells; eosinophils were rare, and polymorphonuclear cells were never conspicuous. Even in these specimens there were spots which consisted only of connective tissue, with no leukocytes. In some cases the entire lymphatic layer was replaced by loose connective tissue or by hyaline connective tissue.

The connective tissue presented differences as far as quantity was concerned. In the majority of specimens it was more abundant than it usually is in specimens from younger persons. The connective tissue was loose, frequently even edematous, or it was firm. In the latter case there was frequently marked development of hyalin. There was, as a rule, no infiltration with leukocytes.

The elastic tissue presented marked individual variations as far as quantity was concerned, but there is no known relation between age and development of elastic tissue. Only in 9 specimens was the bone of the inferior turbinate covered with osteoblasts; in 4 it was covered with osteoblasts and osteoclasts, osteogenesis prevailing; and in 3 specimens the margins of the bone was aplastic.

The nasal corpus cavernosum—so-called—is merely a

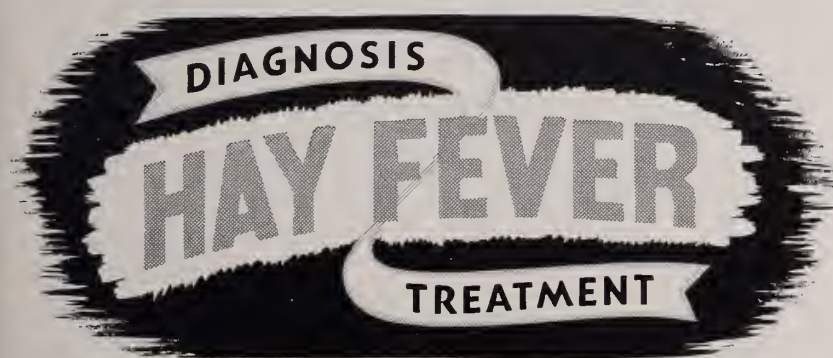
part of the venous system of the nose, not, however, lying between the arterial and venous systems as it does in the sexual organs. It did not show any conspicuous signs. In two specimens taken from persons who died from liver cirrhosis the corpus cavernosum showed hypertrophy in that its blood spaces became increased in number as well as in diameter at the expense of the interstitial and subepithelial tissue of the mucosa.

Active mucous glands were seen only occasionally. The lymphatic accumulations around the glands were poorly developed except in persons in whom death resulted from some acute infectious process such as bronchopneumonia. Frequently the excretory ducts of the glands were each surrounded by a thick ring of hyaline tissue.

The chief alteration with age was a decrease of the lymphatic tissue in the subepithelial layer as well as about the glands. This observation is in accord with that in tonsils and adenoids, in which the lymphatic tissue likewise decreases with age. Yet, since in some specimens there was found a well developed lymphatic tissue regardless of age, one must assume that the age factor is not the sole factor responsible for the decrease of lymphatic tissue in the nasal mucosa. Other probable important causes are the number of preceding rhinologic infections, the general physical state of the subject and the fatal disease. The decrease of lymphatic tissue was followed by an increase of connective tissue, resulting in fibrosis of the mucosa. The fibrosis exerts a deleterious influence on the glands and on the blood vessels. The mucosa of older persons and the mucosa of patients with atrophic rhinitis resemble each other in certain respect, but pathologically and clinically they cannot be considered identical.—M.D.H., M.D.

KEY TO ABSTRACTS

M.D.H. Marvin D. Henley, M.D.



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4.5% . . Carbohydrate . .	4.9%
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87.2% . . . Water . . .	87.3%

Each provides 20 calories per fluid ounce



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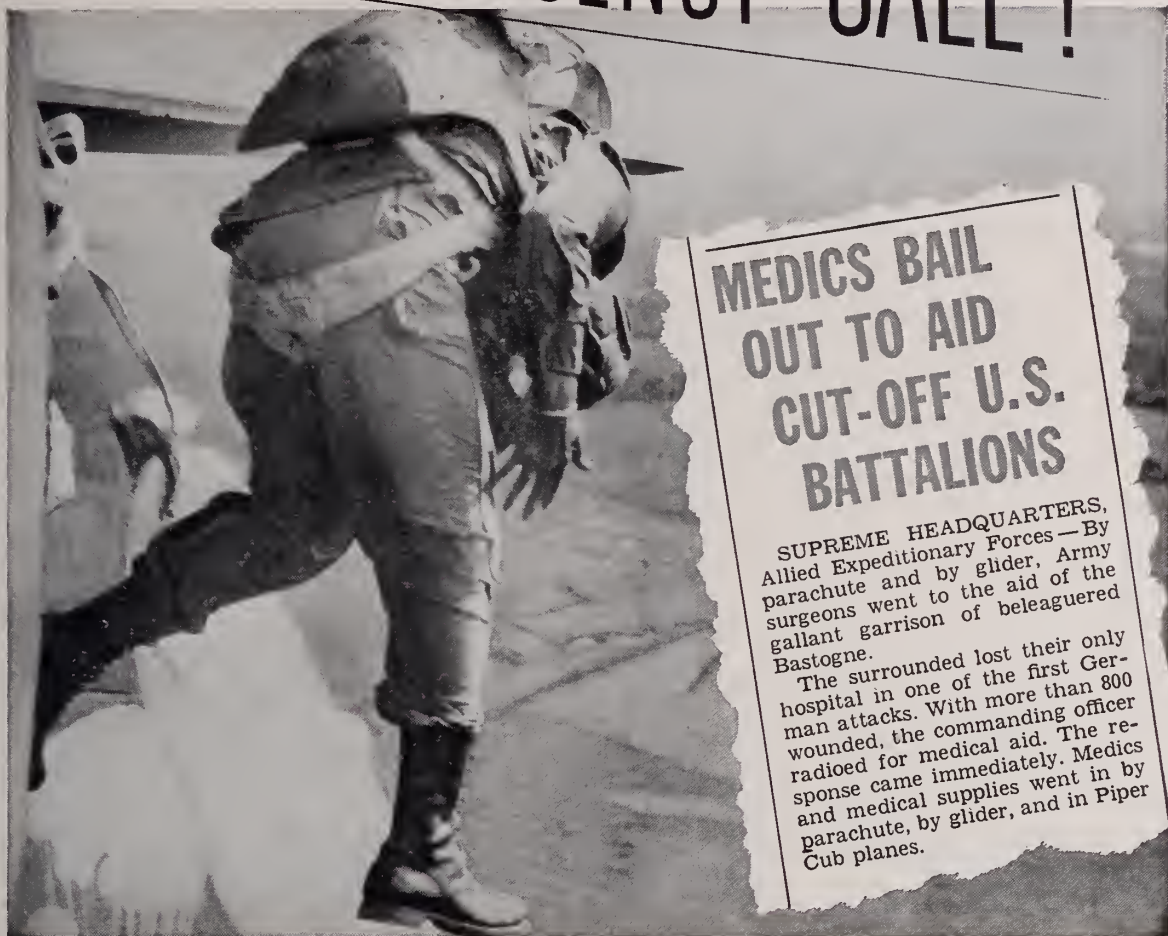
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FAT	29.34 Gm.	THIAMINE	1.296 mg.
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IRON	11.94 mg.	COPPER5 mg.

*Based on average reported values for milk.

OFFICERS OF COUNTY SOCIETIES, 1945



COUNTY	PRESIDENT	SECRETARY	MEETING TIME
Alfalfa.....	H. E. Huston, Cherokee	L. T. Lancaster, Cherokee	Last Tues. each Second Month
Atoka-Coal.....	C. D. Dale, Atoka	J. S. Fulton, Atoka	
Beckham.....	G. H. Stagner, Erick	O. C. Standifer, Elk City	Second Tuesday
Blaine.....	Virginia Curtin, Watonga	W. F. Griffith, Watonga	
Bryan.....	W. A. Hyde, Durant	W. K. Haynie, Durant	Second Tuesday
Caddo.....	C. B. Sullivan, Carnegie	P. H. Anderson, Anadarko	
Canadian.....	P. F. Herod, El Reno	A. L. Johnson, El Reno	Subject to call
Carter.....	J. L. Cox, Ardmore	H. A. Higgins, Ardmore	Second Tuesday
Cherokee.....	P. H. Medearis, Tahlequah	W. M. Wood, Tahlequah	First Tuesday
Choctaw.....		E. A. Johnson, Hugo	
Cleveland.....	Iva S. Merritt, Norman	O. M. Woodson, Norman	Thursday nights
Comanche.....	W. F. Lewis, Lawton	W. C. Cole, Lawton	
Cotton.....	G. W. Baker, Walters	Mollie F. Scism, Walters	Third Friday
Craig.....	Lloyd H. McPike, Vinita	J. M. McMillan, Vinita	
Creek.....	C. R. McDonald, Mannford	Philip Joseph, Vinita	
Custer.....	T. A. Boyd, Weatherford	W. H. Smith, Clinton	Third Thursday
Garfield.....	P. W. Hopkins, Enid	John R. Walker, Enid	Fourth Thursday
Garvin.....	Marvin E. Robberson, Wynnewood	John R. Callaway, Pauls Valley	Wednesday before Third Thursday
Grady.....	Roy E. Emanuel, Chickasha	Rebecca H. Mason, Chickasha	Third Thursday
Grant.....	I. V. Hardy, Medford		
Greer.....	R. W. Lewis, Granite	J. B. Hollis, Mangum	
Harmon.....	W. G. Husband, Hollis	R. H. Lynch, Hollis	First Wednesday
Haskell.....	William Carson, Keota	N. K. Williams, McCurtain	
Hughes.....	H. A. Howell, Holdenville	Imogene Mayfield, Holdenville	First Friday
Jackson.....	C. G. Spears, Altus	E. A. Abernethy, Altus	Last Monday
Jefferson.....	F. M. Edwards, Ringling	J. I. Derr, Waurika	Second Monday
Kay.....	Dewey Mathews, Tonkawa	G. H. Yeary, Newkirk	Second Thursday
Kingfisher.....	A. O. Meredith, Kingfisher	H. Violet Sturgeon, Hennessey	
Kiowa.....	J. P. Braun, Hobart	William Bernell, Hobart	
LeFlore.....	Neeson Rolle, Poteau	Rush L. Wright, Poteau	
Lincoln.....	U. E. Nickell, Davenport	C. W. Robertson, Chandler	First Wednesday
Logan.....	J. L. LeHew, Jr., Guthrie	J. E. Souter, Guthrie	Last Tuesday
Marshall.....	J. L. Holland, Madill	J. F. York, Madill	
Mayes.....	S. C. Rutherford, Locust Grove	B. L. Morrow, Salina	
McClain.....	J. E. Cochrane, Byars	W. C. McCurdy, Jr., Purcell	
McCurtain.....	J. T. Moreland, Idabel	R. H. Sherrill, Broken Bow	Fourth Tuesday
McIntosh.....	Luster I. Jacobs, Hanna	Wm. A. Tolleson, Eufaula	First Thursday
Muskogee-Sequoyah			
Wagoner.....	H. A. Scott, Muskogee	D. Evelyn Miller, Muskogee	First Monday
Noble.....	D. F. Coldiron, Perry	Jess W. Driver, Perry	
Okfuskee.....	W. P. Jenkins, Okemah	M. L. Whitney, Okemah	Second Monday
Oklahoma.....	Gregory E. Stanbro, Okla. City	Ben H. Nicholson, Okla. City	Fourth Tuesday
Okmulgee.....	W. M. Haynes, Henryetta	J. C. Matheney, Okmulgee	Second Monday
Osage.....	G. K. Hemphill, Pawhuska	C. R. Weirich, Pawhuska	Third Monday
Ottawa.....	P. J. Cunningham, Miami	L. P. Hetherington, Miami	Second Thursday
Pawnee.....	E. T. Robinson, Cleveland	R. L. Browning, Pawnee	
Payne.....	Haskell Smith, Stillwater		Third Thursday
Pittsburg.....	L. N. Dakil, McAlester	A. R. Stough, McAlester	Third Friday
Pontotoc-Murray.....	Ollie McBride, Ada	R. H. Mayes, Ada	First Wednesday
Pottawatomie.....	Chas. W. Haygood, Shawnee	Clinton Gallaher, Shawnee	First and Third Saturday
Pushmataha.....	John S. Lawson, Clayton	B. M. Huckabay, Antlers	
Rogers.....	K. D. Jennings, Chelsea	Chas. L. Caldwell, Chelsea	Third Wednesday
Seminole.....	A. A. Walker, Wewoka	Mack I. Shanholtz, Wewoka	Third Wednesday
Stephens.....	W. K. Walker, Marlow	E. H. Lindley, Duncan	
Texas.....	R. G. Obermiller, Texhoma	Morris Smith, Guymon	
Tillman.....	W. A. Fuqua, Grandfield	O. G. Bacon, Frederick	
Tulsa.....	H. A. Ruprecht, Tulsa	E. O. Johnson, Tulsa	Second and Fourth Monday
Washington-Nowata.....	J. V. Athey, Bartlesville	S. A. Lang, Nowata	Second Wednesday
Washita.....	A. S. Neal, Cordell	James F. McMurphy, Sentinel	
Woods.....	O. E. Templin, Alva	I. F. Stephenson, Alva	Last Tuesday
Woodward.....	Roy Newman, Shattuck	C. W. Tedrowe, Woodward	Odd Months Second Thursday

*(Serving in Armed Forces)

THE JOURNAL

of the
OKLAHOMA STATE MEDICAL ASSOCIATION

VOLUME XXXVIII

OKLAHOMA CITY, OKLAHOMA, APRIL, 1945

NUMBER 4

The Management of Urinary Tract Stones^{*}

ALFRED R. SUGG, M.D.

ADA, OKLAHOMA

Among urological conditions there are few that require, for an understanding of their etiology, the exploration of so wide a field as does calculous disease of the urinary tract.

Reviewing the genesis of urinary calculus, one is impressed with the large number of factors which may come into play, either singly or in combination, in any given case. The colloid-crystalloid balance of the urine and the mechanism of chemical precipitation are just beginning to be better understood. The factors responsible for upsetting the normal relationships between the various urinary constituents are so numerous, however, and, in many instances, so obscure as to leave the fundamental question as to ultimate etiology still in doubt.

Indeed, when one considers the variety of stones which have been found in the urinary tract, and the great differences, not merely in size and shape, but in chemical composition as well, one is rather inclined to believe that there are probably a great many different and independent factors at work in any given case; that these factors may be operative in any of a number of combinations; and that, doubtless, no single explanation will ever be found which will be equally applicable to all of them.

The pathological changes which occur in the urinary tract as a result of the presence of calculi, are essentially those due to irritation, obstruction and infection — one or all of these factors being operative in any given case. Calculous disease of the urinary tract is ever changing in its pathological manifestations. Something of a dynamic point of

view, therefore, is required in order to properly visualize these changes.

Therefore, it may be said that all diagnostic efforts should be directed toward the following: (1) a determination of the presence or absence of stone; (2) the localization of the stone in the urinary tract, and its further localization to some particular part of it; (3) the determination and localization of any other co-existing anatomical abnormality or pathological condition in the urinary tract; (4) the determination and localization of co-existing pathological conditions which lie outside the urinary tract; (5) estimation of the functional capacity of each kidney.

It need hardly be pointed out that every patient should be carefully examined from every point of view, whatever his symptom-complex. Serious errors in diagnosis have occurred in the past, due to failure to keep the urinary tract in mind during the physical examination of the patient.

Until the etiology of calculus disease of the urinary tract is better understood, scientific treatment is obviously impossible. It may, however, be necessary to give immediate relief however temporary, in such emergencies as acute renal colic or uraemia. Morphine must be given in large doses and intravenous preferably. It has been definitely shown the ureteral peristalsis is increased by morphine; hence it is certain that the passage of the gravel is impeded by its use, and that smooth muscle dilators such as pavadrine or nitroglycerine would be preferable. The relatively new drug Demerol offers promise here for it is reputed to relieve the pain without stimulating the peristalsis of the ureter.

In cases of persistent or rapidly recurring

^{*}Delivered Tuesday, April 25 before the Section on Urology and Syphilology at the Annual State Meeting, Tulsa.

attacks of colic, however, or where there is total block, ureteral catheterization must be resorted to. By this means the stone may be rotated on its axis or dislodged. Or the catheter may be made to pass beyond the stone. Urinary drainage will thus be re-established and time afforded for a thorough study of the case.

Operative indications in unilateral urinary calculous may be considered under three main heads; (1) cases where operation is not only unavoidable but extremely urgent; (2) those which permit of less positive decision, and where the ultimate disposition of the case is dependent largely upon the surgical and clinical judgment of the physician in charge; (3) those in which operation is definitely contra-indicated.

Of outstanding importance in the first group are those with anuria; those in which kidney is involved in an acute septic process, as in calculous pyonephrosis; those in which renal haemorrhage is severe; or those where the presence of stone results in disabling and frequent attacks of renal colic. The exact size of the concrement is not the determining factor. Of far greater importance is its precise location in the kidney and its potentialities for obstruction, infection and renal destruction. Thus, a small stone which is so located as to constantly, or frequently, obstruct the pelvic outlet should be removed at the earliest possible moment. Otherwise permanent impairment of the kidney may follow. On the other hand, a much larger stone, located in one of the minor calices, may remain there for a considerable period of time without producing any appreciable damage. Its immediate removal may not be at all necessary.

In the second group of cases the indications for operation are not quite so definite. Here the large so-called "silent stone," particularly of the staghorn type, presents the greatest difficulty. It will be remembered that many of these stones are discovered quite by accident, and that they frequently cause little if any inconvenience. Renal function has been found to be surprisingly good in many of the cases. Infection is frequently absent or so slight as to seem essentially unimportant. Moreover, the removal of large staghorn or coral stones usually involves far more damage to the kidney than does the removal of large round stones, or even multiple small ones. Frequently small fragments become broken off and may be accidentally left behind at operation. This may predispose to recurrence at a future time.

Many of these patients live to a ripe old age and die of other causes. The point is often made that, had they been operated upon, their mortality from post-operative com-

plications such as pneumonia, for example, might have been higher; that they might subsequently have had a recurrence of stone, and thus be worse off than before. On the other hand, to permit such stones to remain may be unwise because of their potential capacity for renal destruction, both by pressure atrophy and progressive infection. Moreover, a focus of infection is permitted to remain in the body which may, among other things, tend to act adversely upon the opposite kidney. Though somewhat more difficult to remove than round stones, many have been removed quite satisfactorily, and without untoward damage to the kidneys. Successful permanent cures have been obtained.

In the presence of so many variables obviously there can be no hard and fast set of rules equally applicable to all or even to a majority of the cases. The question as to whether or not to operate can be answered only after a careful study of each individual case. There can be no preconceived plan of procedure for the group as a whole.

Among the factors to be individually appraised in the case of each patient are the following; (1) the degree of discomfort or disability caused by the stone; (2) the severity of the infection, if any; (3) the extent of obstruction to urinary drainage; (4) the progressive or stationary character of the condition; (5) the functional capacities of both kidneys; (6) the probable incidence of recurrence to be anticipated for the particular type of stone believed to be present in the given instance; (7) the probable damage to the kidney which would be caused by an operation as compared with that to be expected from the continued presence of the stone; (8) the age and general physical condition of the patient.

In cases of unilateral ureteral calculus operative removal is usually called for under the following circumstances; (1) if the patient suffers from repeated attacks of renal colic; (2) if the normal activity of the urinary mechanism is being seriously compromised either by obstruction or infection; (3) if the kidney on the opposite side is subnormal or itself the seat of calculous disease; (4) if the stone is so large that it could not pass spontaneously or (5) if it has remained in the ureter for some time, or is increasing in size, and there is no reason to believe that it will be passed in the near future.

Stones which are small enough to pass through the ureter and do not appear to be causing inconvenience to the patient may be permitted to remain tentatively. The incidence of spontaneous expulsion of these stones is relatively high. The patient should, however, be kept under observation. Any increase in the size of the stone or any change

in its position resulting in increased obstruction to urinary drainage should be noted. If there is any reason to believe that the kidney is being progressively injured by its continued presence, either as a result of obstruction or infection, immediate removal of the stone should be considered.

Removal of ureteral calculi may, at times, be successfully accomplished without resort to open operation. This is particularly true when a stone is located in the lower portions of the ureter. Those in the intramural portion respond most readily of all to cystoscopic manipulations. Among the advantages believed to be associated with the removal of ureteral calculi by this means are: (1) the fact that the patient is spared a major operation and all the dangers incident thereto; (2) the possibility of postoperative ureteral stricture is less; (3) an existing stricture may at the same time be dilated; (4) infection of the urinary passages may be quite adequately treated by drainage and lavage as part of the cystoscopic procedure. In some cases pain is the result of the stricture rather than the presence of the stone. Dilation of the stricture may frequently be more effective in relieving the patient's symptoms in such cases than would the actual removal of the stone by operation.

The question frequently arises as to how many attempts should be made to remove a stone by conservative means before finally resorting to open operation. In certain cases a number of successive cystoscopic manipulations have been carried out over considerable periods of time, with no apparent injury to the urinary mechanism, until the stones were finally removed. On the whole, however, it may be said that if removal of the stone is considered desirable, the sooner it is removed the better. There is danger in waiting too long. Particularly in the presence of infection or where adequate urinary drainage cannot be maintained open operation at an early date is advisable.

Furthermore, ureteral manipulations may be dangerous. This is particularly true in the case of a ureter whose walls have been thinned out or congested as the result of an inflammatory reaction. Here rupture may readily result, with a discharge of the stone into the peritoneal cavity. Such accidents have occurred. Also when infection is present, even though it may appear to be very mild, a severe febrile reaction may suddenly be precipitated, necessitating immediate nephrectomy.

The difficulties in obtaining a permanent cure in cases of urinary calculus are primarily due to the obscurity of the etiological factors at work in their production. These factors cannot be properly reckoned with until

they are better understood. Furthermore, in the case of cystine stones, the element of heredity further complicates the picture. However, statistical analysis of such factors as the rate of growth of urinary calculi, their spontaneous passage, their incidence of recurrence, and so forth, all throw some light upon the prognosis.

One might say that prognosis is, generally speaking, good as to life but poor as to permanent cure, since it is dependent upon all the obscure etiological factors operative in concrement formation. To these may be added trauma to the kidney at operation and secondary infection as factors in recurrence.

To recapitulate then, I wish to present briefly what I believe to be a safe and practical attitude towards the management of urinary stones.

Prophylaxis is difficult since it is impossible to anticipate the formation of stone. However, general education in the matter of balanced diet, proper vitamin intake and early attention to such lesions as pinpoint meatus, stricture of the urethra, congenital valves, urinary tract infection, and symptoms referable to the urinary tract in general, would enable the physician to detect stones early enough that corrective measures could be undertaken with safety.

After the stone has developed sufficiently to produce symptoms such as colic, fever, dysuria, etc., and especially for the renal colic prompt, decisive and adequate treatment is demanded. It is unwise to subject a patient to a cystoscopic examination immediately on the first attack of renal colic. Give him a little time and assist with medication, if the stone does not pass, certainly it will give warnings by repeated attacks of colic. If these occur, the next procedure should be an attempt at manipulation.

If the stone is in the lower ureter, the simple division of the ureteral sphincter with a high frequency current is often all that is necessary. I believe that the passage of one or two or even three catheters by the stone, leaving them in place twelve or more hours and then withdrawing them, is about as efficacious as any available measures. To this may be added a five or ten cc dose of depropanex hypodermically and an installation of five to ten cc of avertin through the catheter, in sterile olive oil.

Of course, if there are strictures present below the stone, these can be dilated with catheters and bulbs, and this should be done preparatory to an attempt to pass the stone.

I removed one stone after 9 cystoscopic manipulations, and at the time felt rather proud of my achievement. I would now consider it poor medicine to make more than two attempts at removal.

There is a new type of stone that has made its appearance since the introduction of the sulfa drugs, namely 'the precipitated crystals' of these drugs. The crystals have been known to completely obstruct the renal tubules and produce death, and it is not infrequent to have them precipitate in such quantities as to block one or both ureters. This type of obstruction requires prompt cystoscopic drainage of the kidney pelvis with warm sodium bicarbonate irrigations. Occasionally nephrostomy might be indicated. Stones in the bladder have been crushed with instruments for centuries. It is my opinion that it is safer to do a suprapubic cystotomy and remove the stone than to attempt its removal blindly. However, since the introduction of the cystoscopic rongeur with its powerful jaws and good visual field, these stones now rarely offer any serious problem, for they can be seen and crushed under vision and removed in a few minutes in most cases. If these methods fail, surgery should be resorted to promptly. Watchful waiting may put the patient in jeopardy and increase the morbidity far beyond what may be expected by surgical removal.

If surgery is done before infection ensues, the morbidity is extremely mild and fatalities are rare. If the stone is not left impacted in the ureter long enough to produce fibrosis and ulceration, there need be no fear of fistula or resulting ureteral stricture. If the stone is in the lower ureter, a McBurney's incision, under spinal anesthesia, offers all the exposure necessary. If the stone is higher, a mid-line, or pararectus incision will be quite sufficient and satisfactory.

Round stones in the pelvis offer no problem and are easily removed by simple pelvotomy. Stag horn stones of course present a much more difficult situation. In general, I believe that they too should be removed, for there is no such a thing as a silent stone, and all of them ultimately lead to destruction of the kidneys and chronic invalidism. Here, of course, the age and general condition of the patient, and other factors would need to be considered.

In most cases where indicated, surgical removal of calculi from the urinary tract is truly dramatic in its effects. In chronic cases it relieves the patient of distressing and often disabling symptoms. In emergencies it is a life-saving measure. When stones have been removed after the stone-forming cycle of the individual is over, a permanent cure may be looked for.

Once the stone has been removed the problem of recurrence is the real one. We have the advantage in treatment here, because we are fore-warned and steps can be taken to remove and correct as far as possible all contributing factors. Of first importance is free drainage. The urine must be kept as free from infection as possible and since the advent of sulfanilamide there is, and should be, far fewer recurrent stones. Here prompt diet and attention to adequate vitamin A in the diet is of real importance. In the alkali stones an acid ash diet, rich in vitamin A, together with ammonium chloride and mandelic acid certainly are of value.

Eternal vigilance is the price of success and perseverance will pay dividends.

Severe Head Injuries*

LT. COMDR. HOWARD L. PUCKETT,
M.C., U.S.N.R.

NORMAN, OKLAHOMA

Owing to the present war, there has been a scarcity of neurosurgeons both in the armed services and in civil life. As a consequence many general surgeons have been confronted with grave neurosurgical problems which, in normal times, they would not have had to solve. Many general surgeons have approached this unavoidable responsibility with timidity because of the confusion created by conflicting methods of treatment reported in the literature and taught at vari-

ous universities. This has been especially true in the treatment of severe head injuries^{1,2,3,4,5,6,7,8}.

During the battle for Saipan Island, 89 gunshot wounds of the head were treated without the services of a neurosurgeon. Nine patients died — a mortality of 10 per cent. In comparing the results with those reported in the literature^{9,10,11,12}, it may be worthwhile to consider the method of treatment followed in these cases.

The patients were received in a field hos-

*Read at the Staff Conference, U. S. Naval Hospital, Norman, Oklahoma. January 19, 1945.

pital not later than three hours after injury, with one exception. This one man was injured during a Japanese break-through in our lines and was not found for three days.

Diagnosis as a rule was not difficult — most of the wounds were obvious perforations and, at times, exposing the brain substance. On the other hand, extensive lacerations of the scalp were often present from a bullet or shrapnel without any sign of fracture or even concussion. But the usual findings after such a wound were hemorrhage, shock, grimy ragged tissue, unconsciousness, paralysis, depressed bone fragments, and large defects in the skull and dura.

When hemorrhage occurred it was usually extradural, subdural, and intraparenchymatous all at the same time. In parenchymatous hemorrhage, macerated brain tissue exuded from the wound with the blood. In these patients focal signs, such as hemiplegia, aphasia, and fixed, dilated pupil seemed to depend more on the actual brain damage than upon a bleeding artery, vein, or sinus.

Where the skull defect was large and there was an opening in the scalp through which the blood could drain from the cranial cavity, the patient was often conscious and showed few signs of shock. The extent of injury to the brain substance itself did not necessarily parallel the symptoms. A patient with a hole a half inch wide and an inch deep in his frontal lobe sat up and joked about his condition, while another with no visible evidence of brain damage was unconscious, hemiplegic, and in severe shock. Small scalp wounds when incised frequently revealed extensive defects in the skull and brain with bone fragments peppered into the cortex.

All patients who survived were surgically treated, but not before they were out of shock. Those patients with active intracranial hemorrhage, prolonged unconsciousness, paralysis, obvious contaminated tissue within the wound, bone fragments in the cortex, or large defects in the dura and skull were treated first.

Shock was treated by giving plasma and whole blood when signs of increased intracranial pressure were not marked. If the latter was present, plasma alone dissolved in half the usual amount of water was given; the wound was irrigated gently with normal saline to wash away the blood clot and to promote drainage from the skull; and mucous accumulations in the throat were sucked out.

After the shock was successfully combated, the hair was shaved off and the scalp scrubbed about the wound with green soap and water until all the sand and grit were removed. Anterior-posterior and lateral x-

rays of the skull were made. The skin about the wound was sprayed with merthiolate tincture and anaesthetized with one per cent procaine. The scalp wound was irrigated with normal saline until all gross dirt was removed and then conservatively debrided. When the opening into the skull was small, adequate exposure of the underlying tissues was obtained by rongeur-ing the edges until all bone fragments within the cortex could be extracted without dragging the pieces through normal tissue. Bleeding vessels within the cranium were tied off with black silk and any tear in the sinus was repaired by suture, and muscle transplant if necessary. Blood clots, loose brain tissue, and detritus were washed from the surface by gentle irrigation. If the dura was destroyed so that it could not be closed by suture, a muscle bridge was brought over and sutured in as a filler. The wound was closed except for one end which was left open for drainage.

Trephining was rarely necessary in the treatment because all the initial treatment that was required could usually be done through the compound fracture wound, as described above. On the other hand, when extradural or subdural hemorrhage was found outside the reach of the bullet hole, trephine was done at the site of the suspected hemorrhage.

Sulfadiazine powder was applied to all layers including the cortex, and the patient was given sulfathiazole by mouth at regular intervals. If the patient was unable to swallow, penicillin was given intravenously every four hours night and day for at least three days. Paraldehyde and phenobarbital were used as sedatives. Tetanus toxoid, $\frac{1}{2}$ cc, was given regardless of the previous prophylaxis, and gas-gangrene antitoxin was used in all compound wounds.

In the stuporous patient where the respirations were hampered, oxygen was administered and the patient's head was kept elevated.

A few interesting details of 13 of the most seriously wounded among the 89 patients will illustrate how this method of treatment was applied.

A marine had a bullet hole through the supraorbital ridge which passed to the left occipital region. He was unconscious, and had a rupture of the right eyeball and marked exophthalmos of the left eye with ecchymosis of the surrounding skin. The left pupil was dilated and fixed. Respiration was shallow and 42 a minute; the temperature was 103 F.; the blood pressure was 174 systolic and 38 diastolic; and the pulse was 110, irregular, and full. The extremities showed no muscular resistance to passive movement

and dropped equally with their own weight.

Mucus accumulated in the throat and was aspirated by suction. The wound over the eye was irrigated with normal saline until the clot was washed out and bleeding started again. One unit of plasma dissolved in 150 cc of water was given. The general condition of the patient improved for a few hours. The systolic pressure dropped to 150 and the diastolic increased to 50. The pulse became regular and decreased to 90. Two tablespoons of brain tissue exuded through the wound during this time. Nine hours after admission the pulse and pulse pressure rose again, and on the eleventh hour the patient died.

Two other marines were admitted with compound fractures of the skull from shell fragments. Both were dying and nothing was done in the way of treatment. One had severe injuries of the chest, abdomen and extremities also, and the other had a hole in the forehead two and one half inches in diameter. They died in less than an hour.

A corpsman was brought into the hospital with a bullet hole through his right arm and another through his right eye with the exit over his left ear. He was unconscious; his blood pressure was 154 systolic and 60 diastolic; the temperature was normal; but his pulse was weak and about 140. Considerable blood was draining from both wounds on the head. He was given a unit of plasma and his shock was relieved. The head was shaved and prepared for operation. The skin around the wounds was anaesthetized with one per cent procaine. The perforations in the scalp were thoroughly irrigated with normal saline. The dirt and loose tissue were cut away and the compound wounds in the cranium exposed. The underlying bleeding vessels were revealed by rongeur the bone edges. The torn vessels were ligated and the clots were removed by gentle irrigation. Where the bullet entered, pieces of bone were partially buried in the cortex around a finger-sized cavity in the brain substance. These were removed with thumb forceps, the holes sprinkled with sulfadiazine, and the lacerations in the dura sutured with silk. The bone edges were smoothed and filled here and there with bone wax to stop the bleeding. A cotton wick soaked in saline was left over the line of suture in the dura; a bridge of muscle from the scalp was brought down over the defect in the skull; and the wound was closed in layers, except for one end which was left open for the drain.

Within 24 hours after the operation the patient had improved sufficiently to be evacuated by air to a U. S. Naval Hospital in Hawaii. However about ten days later he died there.

The other nine gravely wounded men were treated in general as described above. One, with a shrapnel wound in his occipital, had a hole in his brain one half inch wide and one inch deep. Unconscious and in profound shock on admission 18 hours later, he was able to sit on the side of his cot, drink water without help, adjust his mosquito net, and carry on a normal conversation. Another marine, who had a bullet plow through the outer table of the skull for five inches and send a shower of bone fragments into the cortex of the frontal lobe, complained only of being unable to rejoin his outfit. All nine of these patients were still alive at the last report 30 to 45 days after operation.

Thus it can be seen from this discussion that the patients fell into three categories; first, those who were admitted in a dying condition and were left in the hands of the Church; second, those who were in profound shock and never responded to treatment; and third, those who did respond to therapy survived.

CONCLUSION

Eighty-nine severe head injuries were treated by following sound surgical principles. The mortality rate was ten per cent. No patient was treated while in shock. Plasma, blood transfusions, sulfonamides, penicillin, tetanus toxoid, and early conservative surgery undoubtedly did much to lower the mortality rate^{13,14,15}.

Note: This article has been released for publication by the Division of Publications of the Bureau of Medicine and Surgery of the United States Navy. The opinions or assertions contained herein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

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Para Basedowian Syndromes*

L. S. MCALISTER, M.D.

MUSKOGEE, OKLAHOMA

At the International Congress of Radiology held in Chicago in 1937, Dr. Louis Delherm of Paris, France, was scheduled to read a paper with this same title. Due to the illness of Dr. Dalherm, the paper was not read. However, there was an abstract in the program manual which gave a few of his ideas on the subject.

He divided Basedow's disease into hyperthyroidism and hypersympathicotonus. The former being differentiated by a high basal metabolic rate and the latter by a normal rate. The prominent symptom common to both syndromes being tachycardia or afebrile heart hurry which Graves uses in his classical definition of hyperthyroidism.

Leahy, in his new book, speaks of an apathetic hyperthyroidism with tachycardia and a low basal metabolism and cautions against subtotal thyroidectomy because of the high mortality. He advises a two stage attack.

Hertzler has also spoken of removing the thyroid for tachycardia with a low basal metabolism.

Dr. Delherm advised treating these cases with small doses of X-ray occasionally combined with volta-faradization of the precordium. The X-ray was applied in small doses to the sides of the neck and occasionally to the adrenal regions.

Since July 8, 1936, I have seen and treated two cases. The first case was seen in July 1936, before I attended the Congress and I was at a loss as to the proper therapeutic approach.

Case 1

Mrs. J. K., age 30, called me about 11:30 a. m., July 8, 1936. She was lying on the bed with a history of a "spell" which began about 10:45 the same morning with weakness and trembling and then, to use her own words, she "passed out." Her history revealed two or three similar spells in the past two weeks and furthermore that they had recurred at intervals and more frequently in the Spring for fifteen years. There was no history of epilepsy in the family. She complained of a drawing sensation in the back of the head followed by weakness and trembling and a pounding, rapid heart. No nausea or vomit-

ing. She also stated that two of my surgical colleagues had checked her repeatedly and told her they would advise removal of her thyroid if only her basal reading was higher.

Physical revealed a well nourished white female with a pulse of 120 and blood pressure 136 over 98. Eyes were lachrymating, but she stated definitely that she was not depressed and not crying. The pupils were somewhat dilated, but equal and regular and reacted to light and accommodation. Oral temperature was 99.2 and later 99.8. Twenty minutes later, the blood pressure was 124 over 78 on both arms, but pulse was still 120. There were no signs of ataxia. The knee jerks were hyperactive, no clonus. Babinski negative. Auscultation revealed no shocks, thrills or murmurs. A basal reading was plus 4.1. Fasting blood sugar 92.1 milligrams.

The patient was seen again August 12, 1937. Pulse 124. Blood pressure on right arm 140 over 80, left arm 136 over 80. Last period August 1 to 5 normal. Weight today 116 pounds. It was found that she was in the habit of drinking 12 to 20 ordinary tumblers of water daily except when busy. Twenty-four hour urine was about four quarts and negative except low specific gravity.

August 21, 1937: Blood pressure 134 over 93; pulse 114. Heart looked normal under fluoroscope. 150 r through 4 mm. aluminum was given to thyroid and she was told to use $\frac{1}{2}$ c.c. pitressin intranasally. She had another "spell" the next day.

August 26, 1937, she called and said she drank four quarts of water from 7 a. m. August 25th to 7 a. m. August 26th and excreted three quarts. Prescription was given for pituitary grains 1/10, Ergotin grains 1 with instructions to take one t.i.d.p.c.

August 28, 1937: Pulse 106, no difference in urinary output. Blood pressure 120 over 80, weight 115, tremor slight, voluntary apnea 5 seconds. She was advised to cut her salt intake way down and 75 r was administered to each side of neck through 4 mm aluminum at 16 inch distance; 50 r to the adrenal regions through 6 mms. aluminum at 20 inch distance. These treatments, I admit, were empirical, but I now felt justified

*Delivered at Annual State Meeting, April 25, 1944 in Tulsa.

after seeing the abstract of Dr. Delherm's paper. On the basis of tachycardia, dilated pupils, lachrymation and tremor, it was felt that the case was more of a hypersympa nicotonus than it was diabetes insipidus. Neurocirculatory asthenia, paroxysmal tachycardia and even hysteria were also considered in the differential.

She received similar exposures on September 4, 1937, October 12, 1937, October 13, 1937, October 25, 1937, November 20, 1937, November 3, 1938, and November 9, 1938, at which time her pulse was 84, blood pressure 122 over 70, weight 120. I questioned her husband the latter part of last month and he stated that she had had only two "spells" since the last exposure and that they were very mild and resulted from severe nervous shocks or emotional upsets. Her fluid intake and output are not abnormal.

Case 2

Miss E. V., age 24, was first seen April 15, 1940, complaining of fast heart, weakness, poor appetite and a history of having consulted three good local men and also having been studied at the University Hospital. Thyroidectomy would have been advised except for the low basal metabolism. Her pulse was 148 and blood pressure 110/30. The basal metabolism was normal, weight was 101. She had been unable to work for several months and the family was poor so a complete workout was not done, but the heart looked normal under the fluoroscope and the only positive findings were tachycardia and apathy. X-ray therapy was suggested but the patient disappeared and was not seen again until March 24, 1942, at which time her pulse was 140, blood pressure 130 over 90 and weight 101½ pounds. She had decided to try X-ray therapy. In the meantime, I had made a working diagnosis of apathetic hyperthyroidism, or at least some type of para Basedowian disturbance.

As I stated above, the apathy was very marked and this symptom seemed to govern the intervals between treatments for she was treated hit and miss at long and at short intervals until November 1943, at which time her weight was 114 pounds, pulse 80, blood pressure 120 over 80.

She obtained a job in November 1943, her first since sometime in 1939, and went along very nicely until February 24, 1944, on which date she came stumbling into the office with nausea and vomiting and a pain in her right side. She stood the appendectomy very well, but her weight dropped to 104½ and the pulse has since reached 120 although under treatment it has dropped to 106.

She has already received about 3750 r bilaterally to the thyroid through 0.5 copper

at 50 cms through a 7x7 cm. port. Treatments will probably be discontinued at about 5000 r bilaterally, but what the final result will be I am unable to say. The patient and I are both very hopeful and she seems very grateful for the beneficial effects of the X-ray obtained so far.

Two cases simulating Basedow's disease have been reported. Both were told by good surgeons and clinicians that if their basal readings were higher, thyroidectomy would be indicated. While a perfect result has not been achieved, they have both been materially benefitted and they have been kept out of the hands of the various cults. As you have noted, both showed a gain in weight and a noteworthy amelioration of their symptoms. No faradization equipment was available or the results might have been more impressive in Case 1.

The Poetry of Duty

Medicine is almost inevitably a matter of ethical relations and of treading the path of duty. It is, in some relations, far from a pleasant profession, yet the physician must always cultivate cheerfulness, good humour and that goodwill toward his fellow creatures which alone "makes insight." Dealing, as he does, daily and hourly with all forms of physical and mental suffering, the doctor cannot consciously adopt loose morals or frivolous standards without losing caste, even within the tribunal of his own conscience. In spite of smoking-room jests, and the large humorous perception of life required of him, his patients alone, in their helplessness and misery, will constantly remind him that "want of decency shows want of sense."—F.H.G., *A Physician's Anthology of English and American Poetry*, pp. xiv-xv.

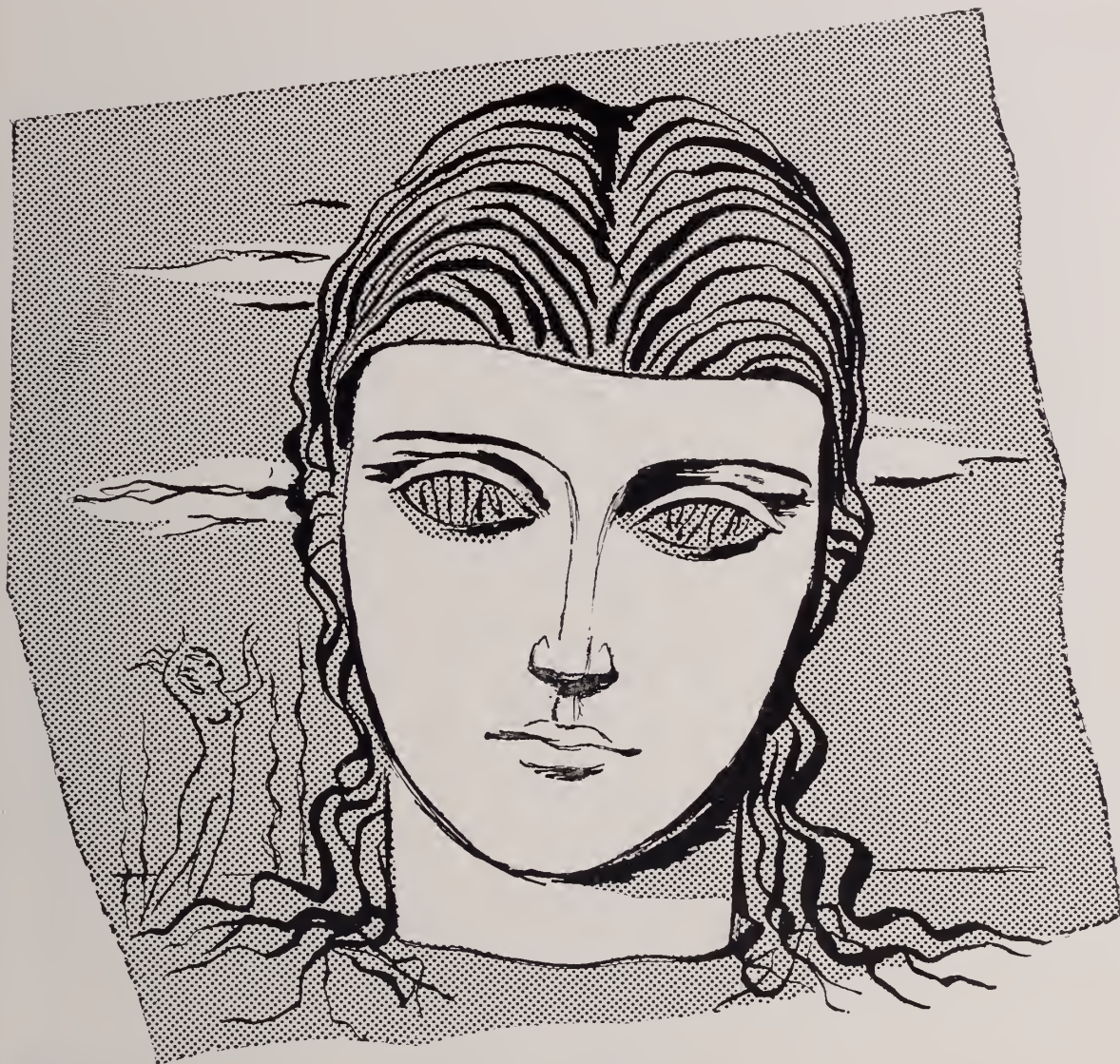
A Toast to the Man Who Takes a Good Doctor's Place

Here is a toast that I want to drink,
To a fellow I'll never know,
To the fellow who's going to take my place
When it's time for me to go.
I've wondered what kind of a chap he'll be
And I've wished I could take his hand,
Just to whisper, "I wish you well, old man,"
In a way that he'd understand.
I'd like to give him the cheering word
That I've longed at times to hear;
I'd like to give him the warm hand clasp
When never a friend seemed near.
I've earned my knowledge by sheer hard work
And I wish I could pass it on
To the fellow who'll come and take my place
Some day when I am gone.

—Dr. Walter Lathrop. *Pack Up Your Troubles*, p. 182.

The Physician a Realist

The physician's calling makes him a realist. If he is to manage patients afflicted with grave diseases, and, it may be, graver wounds, he must master and school his emotions. He cannot afford to be mastered by them. He, of all men, must avoid what Stuart Mill stigmatizes as "slovenly habits of thought, and subjection of the mind to fears, wishes, and affectations."—F.H.G., *A Physician's Anthology of English and American Poetry*, p. xviii.



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THE PRESIDENT'S PAGE

We come to the close of another year in the history of the Oklahoma State Medical Association. Some of the projects which we sponsored have failed to materialize; others have reached a glorious conclusion. This is as it should be. No program is apt to be completed in one year. This is a good argument for a continuity of effort.

It is a pleasure to express my sincere appreciation and thanks to the membership of the Association who has given me such fine support. Without your help all is in vain. You have shown in no uncertain way, by your response to our calls for help, that you are aware of the problems of medicine and are willing to defend them at whatever cost. This fine spirit of cooperation will, in the end, prevail enabling the cause of medicine to continue to serve the people in an independent and scientific way.

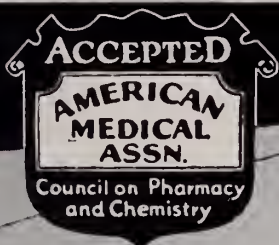
We thank also the staff of the executive office for their fine spirit of helpfulness and loyal devotion to duty. Without their assistance we could have done nothing. In this connection we express our gratitude to Paul Fesler for the magnificent work he has done as Executive Secretary.

To the members of the various Committees, both standing and special, we extend our sincere thanks for their fine work. The Committee work has been exceptionally good this year and much constructive work has been done for the benefit of the Association.

Lastly, I want to ask your cooperation and support to the President Elect. He is one of the finest men I have had the pleasure of knowing. His sense of loyalty to organized medicine, his keen insight to our problems, and his untiring energy, are the attributes of a great leader. Under his direction we are sure to have a most successful year. We all hope and pray that by this time next year the status of the war will permit us to continue our annual meeting.

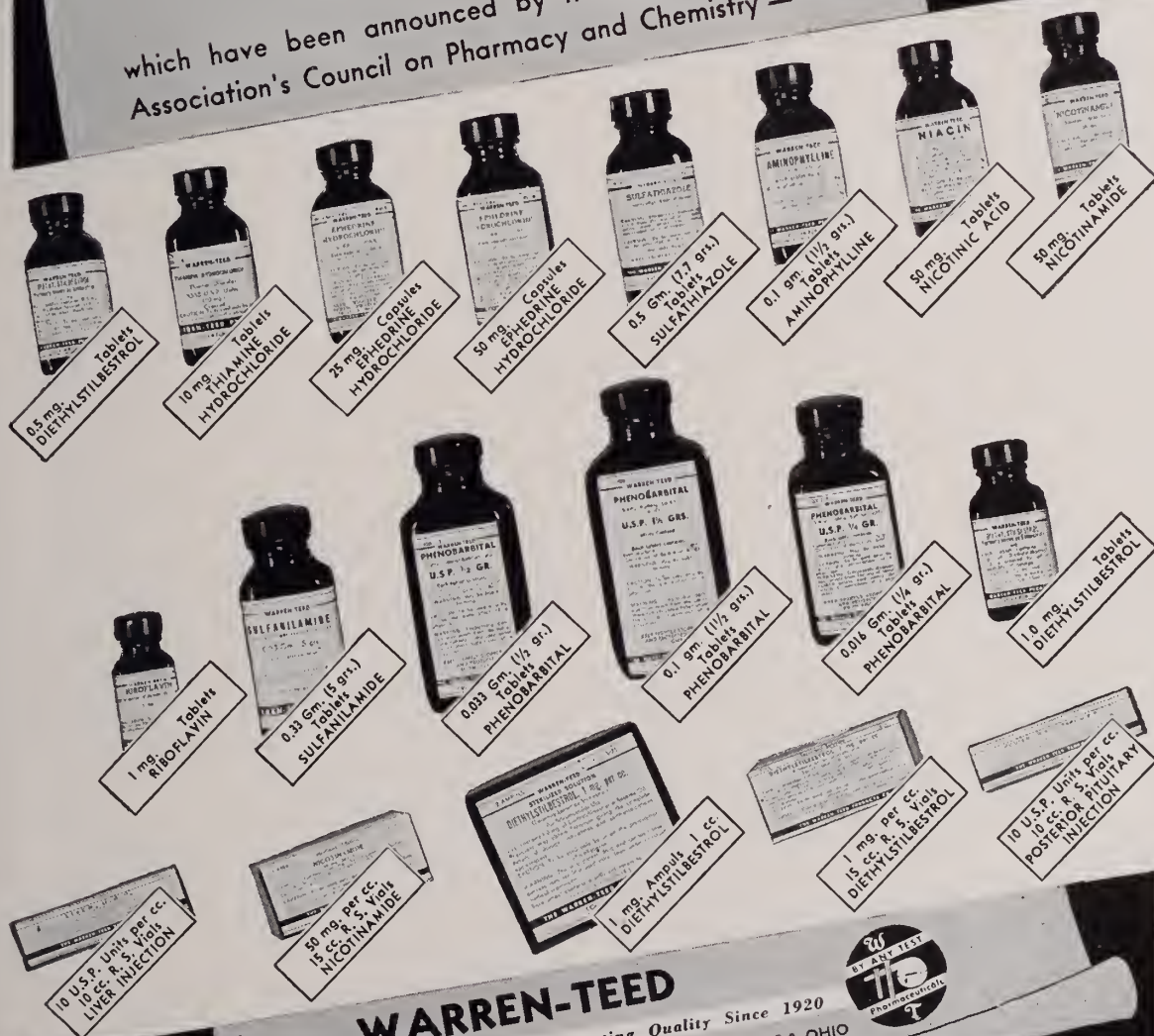


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EDITORIALS

CANCER

The war on cancer is a world war, and the ultimate outcome is largely dependent upon eternal vigilance on the home front. Today the news is not good. During the past two or three decades cancer has moved up from fifth to second place in the lines held by the chief causes of death. In spite of widespread interest in Cancer and lay organizations for its recognition and treatment, all arising through fear, doctors must lead the fight.

While we await additional knowledge, there is much to be done. Doctors, from the most remote rural districts up to the teeming metropolitan areas, must be on the alert for the slightest symptoms and signs of Cancer anywhere in the body; quick to apply all available diagnostic facilities and being ever ready to refer the patient to suitable specialists and to laboratories for diagnostic tests as indicated. At the present time doctors can offer no specific measures in the treatment of this destructive condition but the American College of Surgeons has recorded approximately 40,000 five-year cures. It should be remembered that only doctors can save the victims of cancer. If we permit the lay agencies in this war to rush to the front

without the ammunition which only medicine can supply, the situation will be most embarrassing. Whether we like it or not, the war is on, and there can be no effective advance without the leadership of medicine. With the implements of warfare now at hand we must advance while hoping that out of the laboratories, cancer institutes, and tumor clinics may come more effective defensive and offensive measures.

To aid every doctor, in whatever department of medicine he may be found, we quote the following essential points in the examination for cancer suggested by Zimmermer.¹

"Examination of the lips, tongue, cheeks, tonsils, and pharynx for persistent ulceration, especially in the presence of a history of hoarseness or persistent coughing. In the latter case, a roentgenogram of the chest may be needed.

"Examination of the skin, of the face, body, and extremities for scaliness, bleeding warts, black moles, and unhealed scars.

"Examination of every woman's breasts for lumps or bleeding nipples.

"Examination of subcutaneous tissue for lumps on the arms, legs, or body.

"Investigation of any symptoms of persistent indigestion or difficulty in swallowing and palpation of the abdomen.

"Examination of lymphatic system for enlarged glands, especially in the neck, axilla, or groin.

"Examination of the uterus for enlargement, laceration, bleeding or new growths; bimanual examination to determine condition of ovaries and tubes.

"Examination of rectum, always important even in the absence of symptoms.

"Examination of urine for blood.

"Examination of bones and a roentgenogram of any bone that is the seat of pain.

"Examination of blood.

"Careful examination and a roentgenogram if indicated when the history or physical findings point to abnormality in any other organ or tissue."

If we win this war we must diagnose cancer early. If we diagnose cancer early we must ever be on the lookout for the earliest symptoms and signs. If we are ever on the lookout, we would not dare do less than apply the above listed essential points. While wondering how the war lords can ever atone for the lives they are now destroying, doctors must think of the daily loss of life from cancer because well known diagnostic, preventive and curative measures are imperfectly applied or carelessly omitted.

1. Zimmerer, Edmund G.: Cancer Control, a Doctor's Program. Jour. of Iowa State Medical Society. Vol. XXXV, No. 2, page 41. February, 1945.

WHAT THEY ARE THINKING

In the Editorial columns of the last issue of the Journal, a patient was permitted to speak out concerning regimented medicine. The following comment, from a young Oklahoma City doctor, now overseas, was inspired by a recent issue of the Oklahoma State Medical Journal. It is to be hoped that our own thinking and our own actions on the home front may be conditioned by these unsolicited reflections upon the future of medicine.

"It is a grand feeling to know that someone at home is working for good medicine. . . Many of us here hope that Socialized Medicine never comes, as we are fighting for something in principle that is so foreign to socialized medicine. I would hate to believe that my long stay on foreign soil has been in vain. I am proud to be a part of this great Army, and if I do say so, I believe I have been a good soldier, which I realize is necessary for efficiency. When this affair is over I would like to practice medicine my own way."

OUR OWN PAUL SCORES HONORABLE MENTION

In the "Small Hospital Competition" Paul Fesler collaborating with George Blumenauer, architect, submitted plans for a 40-bed community general hospital which received honorable mention and one of the six prizes offered. Details of the competition and presentation of the prize winning plans appear in the March, 1945 issue of The Modern Hospital.

Two pages are devoted to the Blumenauer-Fesler plans. The following statement, giving a partial list of Paul's past accomplishments and accompanied by his picture, will be of interest to our readers.

"Paul H. Fesler upheld the honor of the hospital consultants by collaborating with George Blumenauer. Now executive secretary of the Oklahoma State Medical Association, as well as hospital consultant, Mr. Fesler at various times in his career as hospital administrator headed the University of Oklahoma Hospitals; University of Minnesota Hospitals; Wesley Memorial Hospital, Chicago; State Tuberculosis Sanatorium, Ah-gwah-ching, Minn., and Business Manager of St. Louis County Sanatorium, Nopeming, Minnesota."

If any of our readers are interested, Paul will be delighted to display plans and supply all available details.

MEETING THE DEFICIT

A reduction of 15,000 civilian physicians by 1948 means that the grizzled old medics on the home front ill have to gradually get on with less leisure and less sleep in order to keep up the quantity and quality of medical service. As long as life lasts they will live up to their clear-cut obligations. This will be difficult but it will be much better than Government regimentation in a futile effort to give better service. Obliterate the individual obligation and immediately the quality will lag. Establish bureaucratic methods with limited assignments and the quantity will show a sharp decline. Fine-print blanks, bulletins and directives will make serious inroads on both quality and quantity.

Finally, all good doctors would rather die of hard work than to be killed by thwarted ambitions. In the face of threatened slavery we fight for the freedom of both patient and doctor. The government can help by deferring induction of medical students. This is proposed by the Ellender Bill (See A.M.A. Journal of March 10, 1945.).

THE MEDIASTINUM IN INFANTS AND CHILDREN

Shapiro and Bell¹ have presented a most significant discussion of the "widening" of the mediastinum and the resulting pitfalls in diagnosis. In this editorial notice attention is called to some of the pertinent facts having to do with diagnosis from the standpoint of the Roentgenogram.

The authors call attention to the fact that infants and children not infrequently have been kept in hospitals for months and years because of Roentgenographic evidence of "widened mediastinum" or "enlarged" mediastinal or tracheobronchial lymph nodes. This was due chiefly to the fact the subjects were Roentgenographed in the horizontal position. When the upright position for pictures was adopted, many of the patients were discharged because of a sudden disappearance of the "widened" mediastinum as determined by a study of the Roentgenogram. Calling attention to only a few of the factors concerned will suffice to put doctors and Roentgenographers on guard.

The authors report that the upright postero-anterior position with the exposure at the end of inspiration proved most satisfactory. Among the conditioning factors is the influence of position. Cunningham states that a study of the cadaver shows that the mediastinal structures have room to move backward or forward in response to the force of gravity. In the supine position these structures gravitate to the inflexible posterior thoracic wall and meeting this unyielding wall they perceptibly extend laterally. This lateral spread is augmented by the resulting elevation of the diaphragm and by relative engorgement of the superior vena cava and the innominate vein on the right and the subclavian vessels on the left.

When pictures are made with the patient in the prone position, the widening is less obvious because the various structures are nearer the anterior chest wall and because they rest partially upon the intervening resilient lung tissue. It is easy to see how the upright position takes care of many of these conditioning factors. Even inspiration and expiration is accompanied by a synchronized widening with expiration and narrowing with inspiration.

Obviously a diagnosis should not be made from horizontal Roentgenograms. Also it should be remembered that long ago Pancoast said, "unless there are clinical evidences and lateral x-rays of the neck to show definite buckling of the trachea, it is impossible to make a diagnosis of enlarged thymus."

If the above factors are kept in mind, there will be fewer diagnostic errors.

1. Shapiro, A. V. and Bell, L: American Journal of Roentgenology. Vol. 49, page 159. February, 1943.

IN THE MORTAR

During the past ten years the New Deal has been pounding the medical profession in a mortar. From time to time bits of unwarranted criticism have been added in order to disguise the true nature of the dangerous concoction. If the pestle holds out long enough, the lawmakers and the bureaucrats some day may pour the bitter dose down the throats of a gullible populace with the promises of a medical paradise.

Unfortunately for the ambitious politicians, who are pounding the progression, panaceas never pan out in medicine. Their family physicians may have to prepare poultices for their aching pates in propitiation for this propaganda.

SELECTIVE SERVICE STATISTICS

One of the primary reasons for promoting change in the present methods of medical practice has been the statistics compiled by selective service which shows more than four million young men rejected for military service because of physical and mental defects.

Approximately one sixth of these defects are classified as remediable and a greater percentage preventable — particularly in childhood. From these statistics is deducted that our people are not getting proper medical care under the present system.

But such statistics are capable of various interpretations and deductions. Equal emphasis has not been given to the facts that negroes contributed more than 44 per cent of the rejections for mental deficiencies and 60 per cent of the rejections for venereal disease. Further, the effect of a lack of self interest or unwillingness to accept treatment or ignorance of the importance of defect has not been considered.

The ability to emphasize but one facet of the entire picture so noticeable in the report of the Committee on the Cost of Medical Care a few years ago is again in evidence. A bit of broadening seems to be indicated for them. At best the Selective Service Statistics prove the old adage that there are plain lies — lies — and statistics!

PUBLIC HEALTH

Today public health is receiving well deserved renewed attention. To list the concrete essentials which make for health and which have come into the pattern of life in the past three quarters of a century, would be an insurmountable task. Suffice it to say that the formal fabric of public health administration was barely getting under way when we entered the last quarter of the 19th Century. Since that time medicine has been the chief participant in the creation of public health principles, the discovery of innumerable human weal boons and their application through the public health movement. For the benefit of humanity it has considered every conceivable phase of social, civic and industrial relations which affect individual well being. Though the inventions which have contributed to comfort, cleanliness and healthfulness have been conceived and developed chiefly with a view of personal gain or advancement, public health has turned them to general advantage as rapidly and widely as circumstances permit. Without this motivation and integration, public welfare would be lagging far behind its present peak. It is well known that propelling power of steam was impotent until the man-made

mechanism of the engine supplied the harness necessary to engage the potential power. So the relationship between modern improvement in living conditions and public health.

If applied, public health had not been well under way before the first quarter of the 20th Century with its mounting hazards, consequent upon the upsurge of mechanistic industry and the irresistible trend toward increased urbanization of population we would have been utterly engulfed in disease and disaster.

Fortunately, public health stood ready and the people individually and en masse were willing to give reasonable cooperation in the application of protective and preventive measures and awakened industry caught the cue and with few exceptions cooperated generously. It is unfortunate that the general public, the greatest, yet the most difficult general in the world, in its present state of enlightenment, knows so little about the true significance of medical science in connection with the power to carry on in relative comfort and health with an average longevity of 63 instead of being snuffed out at 30 by the various health hazards now controlled through the application of medical science.

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ASSOCIATION ACTIVITIES

THE LAYMEN'S CANCER CAMPAIGN

By EVERETT S. LAIN, M.D.
NATIONAL BOARD OF DIRECTORS

One public health problem, cancer, according to health writers, has now become a National Health Emergency. The toll of cancer has continued to grow now, 165,000 per year, until it has become public health problem number one, ranking second only to heart disease. It has been estimated that since Pearl Harbor, cancer has caused the deaths of even more than have been killed in the present war. Statistics further reveal that there are now 37 times as many deaths from cancer as caused by Infantile Paralysis. The public has contributed approximately \$340 per case for the care of Infantile Paralysis, whereas only 50 cents per case for cancer.

By act of Congress, 1937, April was designated the month for cancer education. After learning of these startling revelations some weeks ago, an outstanding layman of the U. S., Eric Johnston, President of the National Chamber of Commerce, after a conference with the American Cancer Society, and Emerson Foote, another well known business man of New York City, volunteered to lead in raising a total sum of \$5,000,000, for *cancer research, education and diagnostic clinics*. This organization is further pledged to continue such financial support of medical science until more definite discoveries of cause and control of cancer can be established. Now approximately each of our 48 states have already set up a campaign committee composed of public spirited laymen, and State Medical Society Cancer Committees. During April and May it is hoped to underwrite the total sum of \$5,000,000.

The amount of \$150,000 has been designated as Oklahoma's quota of the total sum. Of the total amount raised 50 per cent is to remain in the state to be used according to a working project set up by a Board of Directors composed of eight physicians, members of our State Medical Association, Cancer Committee, Mrs. E. Lee Ozburn, women's Field Army, and seven laymen selected by L. C. Griffith, State Campaign Chairman and his aids.

Any one or more of the three primary projects set up by the American Cancer Society, viz., 1. Education; 2. Research Laboratories and 3. Detection and Indigent Service Clinics, may be undertaken by the various state organizations. In order that all research, detection and service clinics may be coordinated and duplications avoided the working projects set up by our State Board of Directors must be submitted to a similar National Committee selected by the American Cancer Society for final approval or modifications.

Not less than 40 per cent of the total funds raised shall be devoted to the problem of research. All possible hitches or bugs of previous money raising campaigns have after long hours and days of thought and discussion by your National Board of Directors, been eliminated or have had safe guards placed around them. The National Board is composed of well known deans of medical schools, surgeons, gynecologists and radiologists. It is indeed gratifying and cause for rejoicing that Eric Johnston, President of the National Chamber of Commerce, has accepted the responsibility of National Chairman and such other men as Senator Rayburn of Texas, H. V. Kaltenborn, public radio commentator, and other men of like national note and public confidence have accepted the challenge to help medical science raise the needed funds for an attack upon this dread disease.

You will read during April, in many popular magazines and newspapers about this movement. You will hear announcements about cancer over multiple radio stations.

It certainly behooves every member of our State Medical Society to be ready to give correct cancer information and otherwise help put over this campaign which is long past due.

ERIC JOHNSON SETS D-DAY FOR CANCER

By Edith Johnson

It has taken a business man, one of the country's best, to organize a campaign to deal effectually with one of our most dangerous enemies, cancer, the disease that is killing 17 persons every hour, day and night, in the United States. This man is Eric Johnson, president of the United States Chamber of Commerce, who has accepted the chairmanship of the new executive council of the American Cancer Society.

Like countless other healthy Americans, Mr. Johnson had not thought much about cancer until it was brought to his attention. But when he learned that more Americans at home are dying of cancer than are being killed or wounded in the war, he was shocked. He had another startling moment when he began to figure and found that if the present death rate were to continue no less than 17,000,000 of our people, now living, are destined to die of that dread disease.

Like many of his fellows, Mr. Johnson had not realized that babies sometimes are born with cancer and that last year 18,000 children under the age of 14 had died of it. It was distressing to learn that cancer is the No. 1 killer of women between the ages of 35 and 55 and the No. 2 killer of American men.

When he sat looking at these facts, Mr. Johnson was appalled and alarmed. Straightway, then, he began to plan a campaign to collect \$5,000,000 during the month of April, one that is to be an annual event. Making a few comparisons he realized that health drives aimed at diseases that kill far fewer persons than cancer have netted as much as \$10,000,000 or \$12,000,000 in a single year while the American public has allotted only \$750,000 annually for cancer research and control.

Haphazard, is perhaps, not too strong a word to describe efforts to find the cause of cancer, not because of research workers, but because of the sporadic nature of their support. A biologist or chemist would plan a project and then obtain a grant from some foundation. If at the end of one year he had not made the hoped-for discovery, support in all likelihood was withdrawn.

It is Mr. Johnson's intention to organize cancer research on a sound business basis, providing for competent planning, direction and, above all, continuity. Scientists at work on a project will not have to worry about how to meet the rent or pay the month's grocery bill. Neither will they wonder if they will be thrown out of employment six months or one year hence. In other words, they will carry on in much the same manner that scientists labor in the great laboratories of Ford, General Electric, Westinghouse and other big industrial plants. Without distracting factors they will be able to concentrate on the matter in hand.

Another phase of Mr. Johnson's program is one of education. There will be a cancer control school program. Outstanding teachers will be asked to speak on the subject at teachers' conventions and the children themselves will hear cancer discussed in the schoolroom. And why not, when they are among its victims?

Of course, there will be no scary stories about it. They will simply be taught that a cancer cell in the body, like some bandit or gangster, runs amok. They also will learn that when detected and treated early, cancer nearly always is cured.

Mr. Johnson is not blaming anybody for the appalling death-rate from cancer unless blame should lay at the doors of laymen like himself who have not seen to it that the facts were told to the people, the hopeful facts as well as the grimmer ones, instructing the people as to what they can do.

Here is a project in which every man, woman and child can take part. Dimes run into dollars and dollars into thousands, even millions. And it is going to take money to get this first honest-to-goodness cancer program on its way.—*Daily Oklahoman*, March 31, 1945.

CANCER COMMITTEE FORMS PLANS TO RAISE FUND

Dr. Paul B. Champlin, Enid, Chairman of the Cancer Committee, held a meeting of the Committee at the Skirvin Hotel in Oklahoma City on March 28. This meeting was for the purpose of making plans for the Cancer Campaign. \$150,000 of the \$5,000,000 fund which is being raised for research, survey and education is to be raised in Oklahoma.

Mr. L. C. Griffith of the Griffith Amusement Company has accepted the Chairmanship and Mrs. E. Lee Osborn will head the Women's Field Army. Dr. Champlin requested each County Medical Society to appoint a Cancer Committee, the members of the committees to work with the lay organizations in every way possible to aid in the education of the public relative to the importance of the campaign. A general, state-wide committee was appointed, the majority of the members being physicians. This committee will have charge of how the funds are to be used in Oklahoma. Fifty per cent of all the money raised will stay in Oklahoma.

Every doctor in the State should give this full support.

CANCER BOOK TO BE DISTRIBUTED TO ALL STATE LIBRARIES

The Cancer Committee of the Oklahoma State Medical Association has arranged to place the book on "Cancer" in every library of the State. It is felt that these books will be of great value in the educational program in regard to Cancer.

J. B. HOLLIS ATTENDS WASHINGTON MEETING

Dr. J. B. Hollis, Mangum, last month attended the Meeting of the American Legion National Rehabilitation Committee in Washington. Loan and education provisions of the GI Bill of Rights were discussed. Appearing before the Committee were General Hershey, Draft Chief; Paul McNutt, Manpower Commission and General Hinds, Veterans Administration Head.

HOSPITAL PLANS OUTLINED BY GOVERNOR KERR

Governor Robert S. Kerr has stated that his recommendation to the Legislature for a hospital program contemplates the establishment of three additional hospitals and expansion of the University Hospital. The three hospitals will be affiliated with the University Hospital and an expansion of the Medical School and Nurses Training is contemplated.

Plans call for establishing one hospital at the Confederate home at Ardmore, and for two other hospitals, one in northeastern and one in eastern Oklahoma.

It is expected that the hospital in northeastern Oklahoma will be a tubercular hospital with general hospital facilities, the other two to be general hospitals but include facilities for tubercular patients.

The Plan contemplates the State funds being matched by those raised locally, and for Federal aid to be sought to augment State and local funds.

PAUL FESLER SPEAKS TO TULSA CHAMBER OF COMMERCE ON HOSPITAL PLAN

At the request of the Tulsa Chamber of Commerce, Mr. Paul Fesler, Executive Secretary of the Oklahoma State Medical Association, presented the Health and Hospital Program as set forth by Governor Kerr, to the Health Committee of the Tulsa Chamber.

This was a very enthusiastic meeting and it was voted that the Tulsa County Medical Society be requested to outline a hospital program for Tulsa. It was felt that the shortage of hospital facilities was serious, especially for the care of tubercular, chronic and contagious diseases.

The Chamber of Commerce Committee pledged themselves to follow the advice of the Tulsa County Medical Society relative to this important program.

DR. TISDAL ENTERTAINS LORD AND LADY HALIFAX

During the recent visit of Lord and Lady Halifax to Oklahoma, Dr. V. C. Tisdal, Elk City, entertained the British statesman and his Lady at a wolf hunt in Elk City. After the hunt a reception was held. Many people from all over the State attended and the event was covered by newspaper reporters and the National Broadcasting Company.

MEETING OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS CANCELED

The 11th Annual Meeting of the American College of Chest Physicians, scheduled to be held at Philadelphia, June 16-19, 1945, has been canceled. The Board of Regents of the College will meet at Chicago in June to transact the business of the College.

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FIGHTIN' TALK



CAPTAIN ROGER REID, Ardmore, is now stationed somewhere in the E.T.O. He states that, being on the orthopedic service, he has had plenty to do. Captain Reid intends to return to Ardmore after the war.

The following excerpt is from a letter received from LT. COL. JAMES E. ENSEY, Altus, who is serving in France:

"REX BOLEND just called to say he had arrived with a new hospital. He looks well and finds this quite a contrast to the Pacific weather and temperature.

"There are numerous 'Okies' here, especially the old guard such as RAY McLAIN, FENTON SANGER and many others.

"Rest assured that they are each giving a good account of themselves on the field of battle in a manner befitting an Oklahoman.

"I have had a rather rich experience in surgery with this unit in continental operations and hope that the necessity for battle surgery will soon cease in this theatre."

VANCE LUCAS, Tulsa, Class of '42, has completed fifteen months service with the Second Marine Division in the Pacific. He has been promoted from Lt. (jg) to full Lieutenant, and has recently been advanced to the job of Regimental Surgeon.

LT. BYRON W. AYCOCK, U.S.N.R. is in the Aleutians and says that the weather continues to live up to its reputation — the wind blows as hard as it sometimes does in Oklahoma!

MAJOR HOWARD B. SHORBE, Oklahoma City, writes the following from his station in Italy:

"In September, after I made the invasion of Southern France, I was transferred to this unit as Chief of Section, Orthopedic Surgery. It was quite a jump as I left from near Belfast Gap in France to Africa. Soon afterward I came back to Italy. It is quite a change from forward surgery to that of a general hospital. We call our work here reparative surgery and leave the reconstruction to the States.

"After two years I'm ready to give someone else a try at this — but don't see much chance for a while. Orthopods, unfortunately are a scarce article.

"Last week we does here in Italy held a medical meeting in one of the general hospitals. It was about half as big as the Oklahoma City Clinical Society and had representatives (American doctors) from two continents besides North America, and about four countries.

"There were many fine physicians and surgeons in attendance and the papers were very excellent. Naturally, they dealt with war medicine and surgery but many of the problems we have faced and at least partly solved now will be of value at home.

"Due to the naturally slow filtering of medical information back from overseas to civilian publications, most of the advances won't be known for at least six months over there."

After a long time spent in "prodding" we finally hear from CAPTAIN GEORGE L. BORECKY — *two letters!* In the first one he says:

"I have been on the move quite a bit the last three years and have finally wound up in Merrie Ole England; but I still say there is no place like the good old U.S.A. Hope this mess will soon be over and we can all be together again, and live like civilized human beings.

"I have not run across any of the fellows from Oklahoma City — Dr. Foerester has been located near me but now has recently moved to new headquarters. Have had some nice visits with him recently and he looks real well. I had an opportunity to talk to Dr. Rex Bolend just the day before he shipped out of Scotland for France. It was over long distance so our visit was rather short.

"Speaking of your late winter; you should have been over here. It certainly was rough and still going on in full force; and with shortage of fuel you can imagine how pleasant it probably is. Makes one miss the comforts of a nice home and good meals.

In Letter No. 2, "My work takes me all over England and North Ireland so that my time is well occupied, quite a bit of it in traveling by air, and so far I have traveled many hours and miles in various types of bombers. Belfast is a nice part of Ireland, very peaceful and quiet, but of the two cities, London and Belfast, I believe I prefer Belfast. There is always so much excitement in London, have also been in Sheffield and Birmingham, the Pittsburgh of England."

Thanks, Dr. Borecky — and by the way, that "Rose" you have over here is still the prettiest and the sweetest.

As reported last month, CAPTAIN DICK GRAHAM did come by to see us at the Executive Office. He was on a business trip and had occasion to stop off in Oklahoma City for a few days. Needless to say, everybody was glad to see him — and he certainly looked wonderful. He says he is homesick for Oklahoma and will be glad when it is all over. The best regards from Dick to all of you.

LT. RALPH ANDERSON, Tonkawa, writes from his Naval Station in California as follows: "Will be overseas for my second time shortly. Am now stationed in California. It's an interesting fact that the last doctor of this unit had his head gently but definitely removed by a five inch shell and the carrier was sunk! The boys in this squadron are the cream of American manhood and I'm looking forward to this tour.

"I was to take a surgical residency in San Francisco but the Navy changed my plans; will do it after the war or in about three years — I hope."

MAJOR RAYMOND L. MURDOCH, Oklahoma City, has been released from the service and has returned to Oklahoma City where he has resumed his practice.

MAJOR HARL D. MANSUR, JR., Elk City, and as he puts it "former general flunky for Dr. V. C. Tisdal,"



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writes from Assam and says that "Assam and Burma medicine is different than Oklahoma medicine."

CAPTAIN TOM HARMON, Sallisaw, Class of '35, says that he "can't help running into a few O. U. grads kicking around here in France. And it's a darned good morale builder to receive Dr. Tom's letter with the news from home." *Thanks, Captain Harmon!*

The boys overseas are still interested in the legislative problems — even though they have much more on their minds. This is evidenced in the following from a letter received from CAPTAIN HAROLD H. HARMS, Cordell:

"Speaking of postwar conditions — from the tone of articles in The Journal, it sounds as if Oklahoma politics are finally conceding to the medical educational system some of the assistance it deserves, such as appropriations for medical school, hospital, etc. Now, I think I express the opinion of most M.C.'s overseas — especially of we young bucks about to grow old in the service — that we earnestly hope Dr. Tom Lowry gets plenty of help with his endeavors to help re-acquaint us with medicine someday."

CAPTAIN JAMES B. DARROUGH, Vinita, was home recently for a short time before going to his new assignment at Fort Belvoir, Va. While in Vinita he spoke to the members of the Vinita Lions Club about the use of blood plasma, penicillin and sulfa drugs. He also spoke briefly of the rehabilitation work that was making it possible for the miraculous performance of artificial arms and legs for those wounded in the war.

MAJOR MARK D. HOLCOMB, Lawton, recently received a commendation signed by Lt. Gen. Robert Eichelberger. He also received the citation for the Legion of Merit award during the Sanananda, New Guinea campaign in January, 1943.

Major Holcomb was commended for a six weeks' training program he set up for new medical corps recruits in preparation for the next campaign. His regiment was believed to be the only one on the island, recently taken from the Japanese, to have such a program. With three doctors and three non-commissioned officers conducting the classes, they arranged for lectures, demonstrations and social training experience for some medical and surgical technicians on temporary duty in a general hospital.

Capture of Japanese equipment including microscopes, made possible the arrangement of a laboratory where necessary tests could be conducted. Major Holcomb is now regimental surgeon with a collecting company assigned to him in addition to the medical detachment and a portable surgical hospital.

Major Holcomb has been overseas for 33 months and has served in five major campaigns.

CAPTAIN R. W. CHOICE, former Waukita physician, is now serving with the Third Army under Gen. George S. Patton.

LT. COMDR. GERALD ROGERS, Oklahoma City, has been recently commissioned in the Navy.

MAJOR J. R. HINSHAW, McAlester, has been released from the service and recently spoke to the Rotary Club in McAlester on his experiences while stationed in Iran.

Dr. Hinshaw was sent with the "Mission to Iran" in 1942. They were given the job of opening a supply route through Iran up to the Russians so that lend-lease articles could find a way of reaching Russia. This was the largest supply line in the world. His varied experiences on the way over and during the time he was there are quite colorful and interesting.

LT. G. B. DOWNING, Lawton, has been commissioned in the Navy and has been assigned to the Norfolk Naval Station.

A word about the feminine side of the war — the Medical Corps Wives addressed the Woman's Auxiliary of the Medical Association in Tulsa recently. Talks were given relating wartime experiences as wives of doctors in the service. Those on the program included Mrs. Thomas H. Davis whose husband LT. COLONEL T. H. DAVIS was the first doctor from Tulsa county to enlist in the armed forces, and is now Chief of the Surgical Section of a hospital somewhere in England; Mrs. Paul N. Atkins whose husband MAJOR PAUL N. ATKINS is a surgeon in active service with an amphibious engineering regiment somewhere in the Southwest Pacific; Mrs. Samuel E. Franklin whose husband, MAJOR S. E. FRANKLIN is on active duty in Guadalcanal; Mrs. S. C. Shepard whose husband, LT. COMDR. S. C. SHEPARD is on active duty somewhere in the South Pacific; Mrs. Eric White whose husband CAPTAIN ERIC WHITE is attached to a hospital ship that took part in the invasion of Leyte; Mrs. L. A. Munding whose husband CAPTAIN L. A. MUNDING is a flight surgeon with the Central flying training command stationed in Del Rio, Texas.

LT. COMDR. HOWARD L. PUCKETT, Stillwater, has been awarded the Presidential Unit citation for his work with the Second Marine Division in the Southwest Pacific. Lt. Comdr. Puckett is now Staff doctor at the Norman Naval Hospital.

LT. COLONEL RAYMOND H. FOX, Altus, has recently been promoted from Major.

CAPTAIN CURT YEARY, Oklahoma City, formerly reported as missing in action, has now been reported as a prisoner of war in Germany. Also a prisoner is CAPTAIN WOODY PICKHARDT, Bristow.

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MANUFACTURERS

Obituaries

Ralph E. Myers, M.D. 1888 - 1945

Dr. Ralph E. Myers, Oklahoma City, died at Polyclinic Hospital on March 14, following a brief illness.

Twenty-two years a practicing physician in Oklahoma City, Dr. Myers was born in Buskirk, New York and received his A.B. and M.S. degrees from Yale University in 1909. In 1917 he received his medical degree from Cornell University, after which he entered the Army. After the war, Dr. Myers taught medicine at Albany, New York Medical School before receiving a teacher's fellowship at Harvard University, later teaching at the Baltimore Medical School and George Washington Medical School.

In 1922, Dr. Myers came to Oklahoma City and was radiologist and pathologist at St. Anthony hospital until 1929 at which time he entered private practice. He was a member of the Oklahoma County Medical Society, the Oklahoma State Medical Association and the American Medical Association.

Surviving Dr. Myers are his widow, Mrs. Lucy R. Myers of Oklahoma City and one brother, Dr. Victor Myers, Cleveland, Ohio.

R. Delbert Watson, M.D. 1905 - 1945

Dr. R. D. Watson, Britton, died March 14 at Wesley Hospital after a brief illness.

Born at Blair, Oklahoma, he was later educated at the University of Oklahoma, receiving his medical degree in 1929. After graduation, Dr. Watson served his internship at University Hospital. He subsequently had postgraduate work in surgery at the University of Pennsylvania. In 1930 he moved to Britton where he began practice and where he was practicing at the time of his death.

Dr. Watson was a member of the Oklahoma County Medical Society, the Oklahoma State Medical Association and the American Medical Association. He was also a member of the Oklahoma City Golf and Country Club, the Masonic and Odd Fellows lodges and was a member of the Britton Baptist Church.

Dr. Watson is survived by his widow, Mrs. Marie Watson; two children, Marilyn and Delbert; his parents, Mr. and Mrs. I. N. Watson of Blair; two brothers, Lt. Col. L. Newton Watson, Army physician stationed in England and O. Alton Watson, Oklahoma City specialist; one sister, Mrs. A. C. Reid, of Tulsa. Services were held at the Baptist Church in Britton with Rev. B. D. Vanderslice officiating. Interment was in Memorial Park.

A. W. Roth, M.D. 1873 - 1945

Dr. A. W. Roth, Tulsa, died March 17 at his home after a long illness.

Dr. Roth practiced medicine in Tulsa since 1910 and was one of the organizers of the Tulsa Public Health Association. Born in Fairfield, Iowa, he attended Parsons College there, receiving his medical degree from Hahnemann Medical College and Hospital in Chicago. He studied special courses at the Manhattan Eye, Ear,

Nose and Throat Hospital in New York City. Before coming to Tulsa, Dr. Roth practiced medicine in Detroit and Fort Collins, Colorado.

Dr. Roth was a member of the Tulsa County Medical Society, the Oklahoma State Medical Association, the American Medical Association, the American Society of Ophthalmology and the American College of Surgeons. He was also a member of the Ozark Club and the Rotary.

Surviving Dr. Roth are his widow, Mrs. Anna Roth; two sons, John Edward of Tulsa and Rev. A. W. Roth, Topeka, Kansas; one sister, three brothers and four grandchildren.

William P. Greening, M.D. 1875 - 1945

Dr. W. P. Greening, Pauls Valley, died on March 2 at his home following a brief illness. He has been in failing health for some time but had been confined to his home for only a few days.

Dr. Greening was born in Florida, Missouri and was a graduate of the College of Medicine, Louisville, Kentucky in the Class of 1902. After his graduation he located at Wichita, Kansas where he practiced until he later attended the Wills Eye Hospital in Philadelphia, becoming a specialist. He also took postgraduate training in Chicago and New Orleans before coming to Pauls Valley in 1910. During the first World War, Dr. Greening served as a Captain in the Medical Corps.

Surviving Dr. Greening are his widow Mrs. Pauline E. Greening; two sisters and two brothers.

B. F. Vaughan, M.D. 1864 - 1945

Dr. B. F. Vaughan, Bethany, died March 1 in an Oklahoma City hospital, being brought there after a long illness.

Dr. Vaughan was a native of Illinois, where he attended school and medical college. He moved to Oklahoma in 1907 and lived in Lincoln County, near Stroud, until 1921 when he moved to Oklahoma City. In 1927 he moved, with his family, to Bethany, where he continued his medical practice until ill health forced him to retire.

Surviving Dr. Vaughan are his widow, Mrs. Mary Vaughan of Bethany; one daughter, Miss Kathlene Vaughan, Oklahoma City, and one son, Victor Vaughan of California.

Paul W. Friedemann, M.D. 1861 - 1945

Dr. Paul W. Friedemann, pioneer Stillwater physician, died March 15 in a Stillwater hospital.

Born at Heimthal, Russia, Dr. Friedemann studied medicine and became a commissioned officer in the Imperial Russian Army in which he served six years. In 1893 he and his wife came to America and directly to Oklahoma Territory. They moved to Kingfisher County where they helped found the city of Kiel, Oklahoma, now known as Loyal. Dr. Friedemann furthered his schooling in medicine by attending Northwestern University and the University of Illinois. In 1907 he moved to Stillwater where he practiced medicine for 38 years.

Surviving Dr. Friedemann are his widow, Mrs. Friedemann; three sons, William, Theodore E. and A. P. Friedemann; one daughter, Lydia Du Chateau; one brother and six grandchildren.

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*Collins, B. C.: Subacute Bacterial Endocarditis Treated with Penicillin, J.A.M.A. 126:233 (Sept. 23) 1944.

MacNeal, W. J.; Blevins, A., and Poindexter, C. A.: Clinical Arrest of Endocarditis Lenta by Penicillin, Am. Heart J. 28:669 (Nov.) 1944.

Zimmerman, S. L., and Barnett, R. N.: Case of Probable Meningococcus Endocarditis Apparently Cured with Penicillin, South. M. J. 37:694 (Dec.) 1944.

Herrell, W. E., and Kennedy, R. L. J.: Penicillin: Its Use in Pediatrics, J. Pediat. 25:505 (Dec.) 1944.

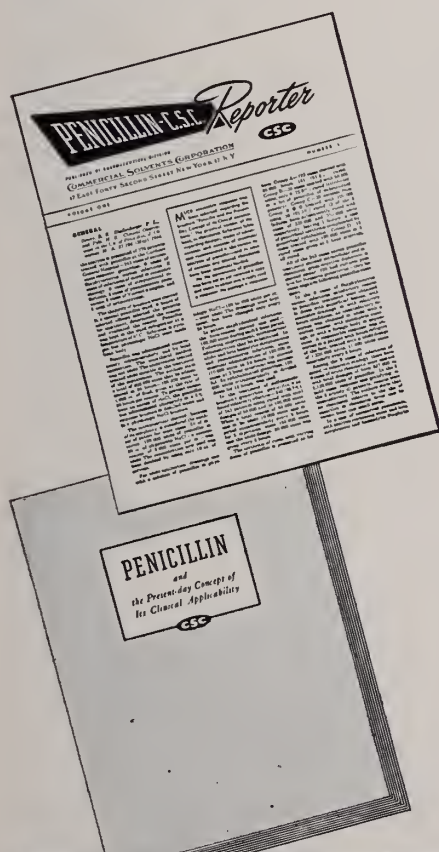
Dawson, M. H., and Hunter, T. H.: The Treatment of Subacute Bacterial Endocarditis with Peni-

cillin, J.A.M.A. 127:129 (Jan. 20) 1945.

Nahum, L. H., and Doff, S. D.: Recent Advances in the Treatment of Heart Disease, Connecticut M. J. 9:3 (Jan.) 1945.

Poindexter, C. A.: The Use of Penicillin in the Treatment of Subacute Bacterial Endocarditis, reproduced by permission of the American Heart Association in J. Arkansas M. Soc. 41:165 (Jan.) 1945.

White, P. D.; Mathews, M. W., and Evans, E.: Notes on the Treatment of Subacute Bacterial Endocarditis Encountered in 88 Cases at the Massachusetts General Hospital During the Six Year Period 1939 to 1944 (Inclusive), Ann. Int. Med. 22:61 (Jan.) 1945.



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Book Reviews

MANUAL OF MILITARY NEUROPSYCHIATRY:

Edited by Harry C. Solomon, M.D. and Paul I. Yakovlev, M.D. W. B. Saunders Company. Philadelphia and London. 1944. 764 pages.

This manual was elaborated on the basis of one privately published by the former superintendent of the Metropolitan State Hospital, Waltham, Massachusetts, Roy D. Halloran. This was the "Collected Lectures" of the "Seventh Postgraduate Seminar in Neurology and Psychiatry, including a Review Course in Military Neuropsychiatry," held at the Metropolitan State Hospital in 1941-42. The postgraduate seminars had been given each year for those who wished to take the examination of the American Board of Psychiatry and Neurology. Those of us who have taken these seminars remember Dr. Solomon as an able teacher of psychiatry and Dr. Yakovlev as one of the few who can teach neuroanatomy and neurology in a way that is entertaining and easily understood. Furthermore we recall the whole course as one of the most clear, simple and practical in our experiences. One is not surprised therefore to find in this manual a series of papers by forty five collaborators which cover the field of neurology and psychiatry in the same clear and practical manner. This makes it of great value to the general practitioner as well as the specialist.

The first three of six sections, covering 127 pages, is devoted to the administrative aspects of military psychiatry. The fourth section, with 341 pages devoted to "Clinical Entities," is the portion of the book with the greatest value to the general practitioner. This covers virtually the whole field of neurology and psychiatry in a succinct fashion. Sample chapter headings are "Psychoneurosis and Psychosomatic Disorders," "Alcohol and Alcoholism," "Sexual Deviates," "Principal Psychoses," "Common Diseases of the Nervous System," "Peripheral Nerve Injuries," "Spinal Cord Injuries," and Post Traumatic Syndromes."

Section five has to do with prevention and treatment of neuroses and psychoses with emphasis on the military aspects of the problem.

The final section "Special Topics" is devoted to the special problems met in the tropics, in convoys and torpedo casualties, and in flying and ends with discussion on spinal fluid and electroencephalographic examinations.

The book is recommended to all physicians as a quick reference book when meeting unfamiliar neuropsychiatric disorders.—*Hugh M. Galbraith, M.D.*

APPROVED LABORATORY TECHNIC. John A. Kolmer and Fred Boerner. Fourth Edition. D. Appleton-Century Company, Inc., New York. 1945. 1017 pages.

The broad purposes of this valuable book are well stated by the authors in the first paragraph of the preface to the First Edition:

"It is hoped that this manual will aid in the fulfillment of several of the objects of the American Society of Clinical Pathologists, namely, to establish standards for the performance of various laboratory examinations, to promote the practice of scientific medicine by a wider application of clinical laboratory methods to the diagnosis of disease and to encourage a closer cooperation between the practitioner and the clinical pathologist."

In this revised Edition, the authors, with thirty well

known collaborators, have placed before the student, the physician and the clinical pathologist a wealth of technical knowledge with specific instructions for its application. Descriptions and techniques are aided and clarified by many carefully compiled tables and 446 well chosen illustrations. New sections and new procedures have been added to cover recent advances in this special field. This feature well illustrates the rapid progress of medicine and the clinical pathologist's ability to keep abreast.

A new section on examination of feces for animal parasites and their products and a similar new section on the examination of blood and tissues for parasites and the rewritten section on mycological examinations are among the manifest responses to our global contacts and concepts.

In the preface to this Edition the authors indicate that "New sections have been added on methods for examinations of the saliva, pancreas function tests, examinations of the blood and urine for hormones, examinations of the blood and urine for vitamins and virological examinations."

Among the many newer methods discussed, the following are taken from the preface because of their general interest: "Various new tests for kidney function, the congo red test for amyloidosis and nephrosis, the Hanger cephalin-flocculation test for liver function, the qualitative analysis of urinary calculi, the frog test of Weisman, Synder and Coates for pregnancy, the fluorescent

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dye method of Richards and Miller for tubercle bacilli, Brewer's plate method for the cultivation of anaerobes, the methods of Reed and Orr for the identification of the Clostridia, the Salmonella group of bacilli in relation to food infections, the cold hemagglutination test of Horstmann and Tatlock for primary atypical pneumonia, methods for detecting the Rh subgroup in relation to blood transfusion, precipitin tests for meningococcus, pneumococcus and Hemophilus influenzae polysaccharides in relation to serum therapy, the serologic tests for syphilis by Boerner and Lukens and Mazzini and the complement fixation tests for lymphopathia venereum, other viral diseases and those due to animal parasites. Special attention has been given the detection of the crystals of the sulfonamide compounds in urine and we are greatly indebted to Dr. John Henderson for the illustrations so kindly furnished. Methods have also been included for testing the susceptibility of bacteria to penicillin and for the demonstration of penicillin in the blood, exudates and other body fluids."—Lewis J. Moorman, M.D.

Medical School Notes

Dr. William Gerald Rogers, Associate in Gynecology, and Dr. Hubert Eugene Doudna, Professor of Clinical Anesthesiology, have been granted leaves of absence from the faculty of the School of Medicine, for active duty in the United States Navy.

Part I of the American Board of Surgery examination was given at the School of Medicine on March 20, 1945. This examination was given under the sponsorship of Dr. LeRoy D. Long.

The Rotary Anns of Oklahoma City recently voted to purchase a Balopticon for the Oklahoma Hospital for Crippled Children.

Dr. Wayne McKinley Hull, Instructor in Medicine, has resigned from the faculty of the School of Medicine, and is now residing in Omaha, Nebraska.

Dr. Charles R. Rayburn has recently resumed his duties as Professor of Mental Diseases on the faculty. He had been on a leave of absence serving with the Army since June 15, 1942.

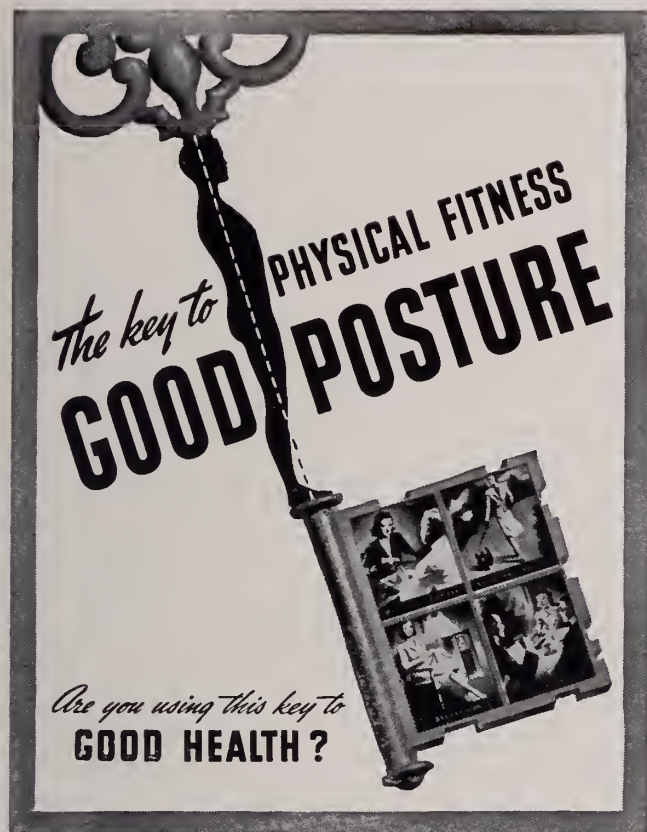
Dr. Mark R. Everett, Chairman of the Research Committee, and Dr. John F. Burton, also a member of this committee, represented the School of Medicine at the meeting of the Medical Advisory Committee of the Office of Research and Scientific Development, held in Denver, Colorado, on March 20. At this meeting, plans for the formation of a foundation for medical research were discussed.

The Phi Beta Pi Annual Founder's Day dinner-dance was held at the Oklahoma City Golf and Country Club in Oklahoma City on March 9, 1945. Alumni members of the fraternity were guests.

New books received at the Medical School Library include: Archer, W. H.: Life and Letters of Horace Wells, Discoverer of Anesthesia, 1944; Chappell, G. S.: Through the Alimentary Canal with Gun and Camera, 1930; Harley, David: Medico-legal Blood Group Determination, 1944; Kelly, H. A.: Walter Reed and Yellow Fever, 1906; Koch, Robert: Actiology of Tuberculosis, 1932; Merchen, J. B.: Charlatanry of the Learned, 1937; New York Academy of Medicine: March of Medicine, No. 9, 1945; Wilmer, H. A.: Huber the Tuber, 1943; Zachariasen, W. H.: Theory of X-Ray Diffraction in Crystals, 1945.

A series of seven paintings, "The Seven Ages of a Physician" by the contemporary American artist, James Chapin, will be exhibited at the Medical School Library

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While the public will be reached through every popular channel of public information, emphasis is again being placed on the distribution of authoritative literature to schools, colleges, medical and gov-

ernment bodies, industrial, professional and civic public health groups.

Physicians, educators and lay groups in the field of public health have shown in practical cooperation and voluminous correspondence that they approve the content and methods of National Posture Week and its year-round physical fitness program. It is our hope that we will continue to merit this support in this year of Victory and during the post-war years of adjustment which will present so many problems to those charged with maintaining the health of the nation.

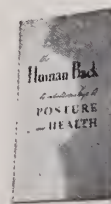
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until April 15. While the collective title, "Seven Ages of a Physician," paraphrases Shakespeare's seven ages of man, obviously it is not presumed to include the paraphrase in the content of these paintings themselves. While each painting must eventually be pictorially sufficient unto itself, the primary conception was of a group of seven interesting units which were to create, in form and content, a functioning whole.

The next University Hospital Staff Meeting will be held April 6, in the auditorium of the Medical School Building, at 7:30 p. m. The program will be as follows: Subject: Carcinoma of the Breast. Analysis of Cases for Five Year Period—Drs. Herman Glanigan and L. F. Shryock. Anatomical Pathways for the Spread of Cancer of the Breast—Dr. Ernest Lachman. Five Minute Discussions by: Dr. H. C. Hopps, Dr. J. H. Robinson, Dr. William E. Eastland, and Dr. F. M. Lingenfelter.

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Man is no mushroom growth of yesterday.
His roots strike deep into the hallowed mould
Of the dead centuries; ordinances old
Govern us, whether gladly we obey,
Or vainly struggle to resist their sway:
Our thoughts by ancient thinkers are controlled,
And many a word in which our thoughts are told
Was coined long since in regions far away.

—John Kells Ingram. *A Physician's Anthology of English and American Poetry*, p. 270.

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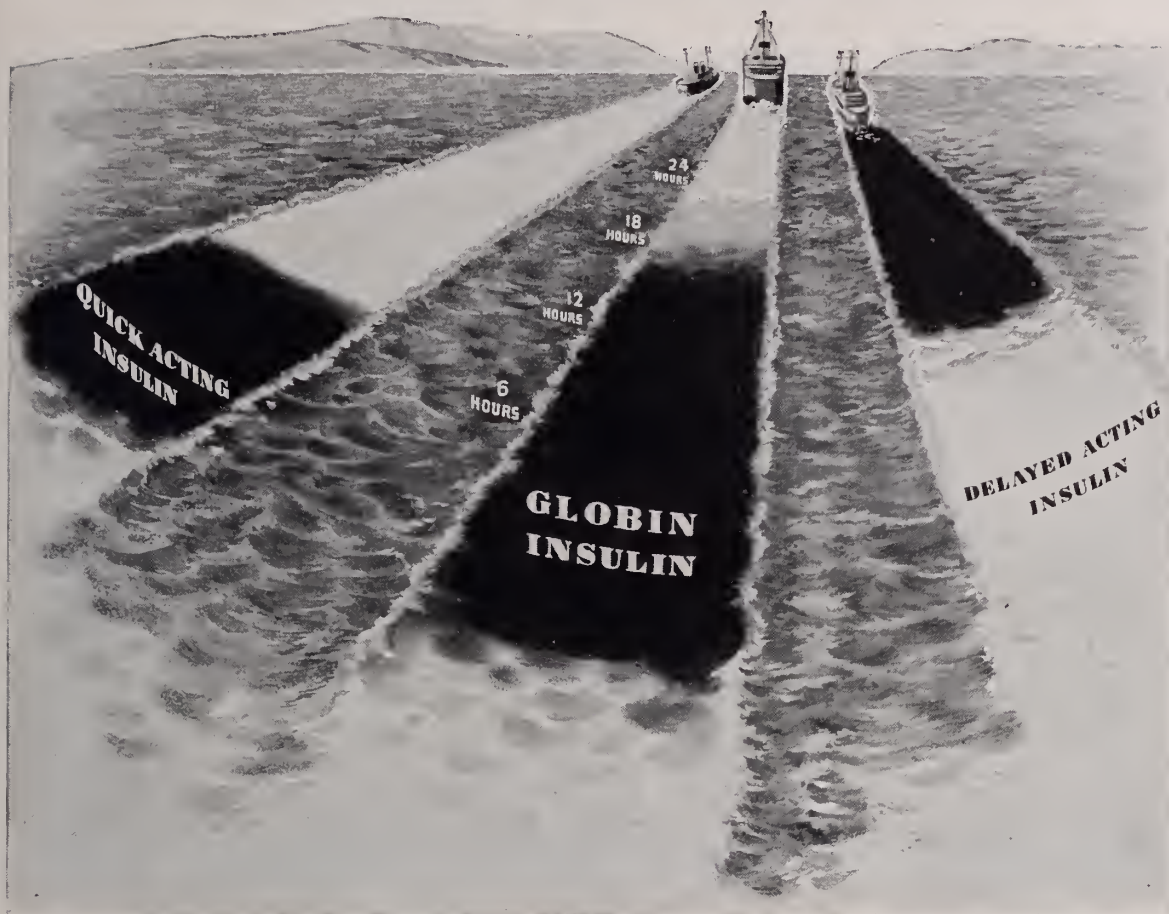
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MEDICAL ABSTRACTS

OBSERVATIONS ON BATTLE FRACTURES OF THE EXTREMITIES. Oscar P. Hampton and Joe M. Parker. *Surgery*, Vol. XV, page 869. June, 1944.

This report covers a study of definite care for approximately 1,400 men with fractures of the extremities due to high-explosive or bullet wounds. Treatment was rendered in a general hospital, which was functioning actively in a zone of communications at a base for a period of eight months. Approximately 98 per cent of the injuries were given first aid and definite treatment in forward evacuation or surgical hospitals. For the most part, the initial care was considered to be good. Sulfanilamide had been used in most instances, either in the wound or orally, or both; within an average of eight hours, 92 per cent of a group of 500 had this prophylactic therapy. In 1,400 cases of compound fractures secondary to high-explosive or bullet wounds, debridement was sufficiently good in the forward medical installations to prevent sepsis in all but fifteen to eighteen cases.

The authors have recommended the filling of the initial compound wound loosely with petroleum-jelly gauze. They have strongly and wisely advised against tight packing of the wound.

Primary internal fixation in compound fractures caused by high explosives is considered unwise, and will fail in most instances. Pins for skeletal traction or for plaster fixation, which were inserted before the patient reached the base hospital, produced a high incidence of

complications. Padded casts were found to be more satisfactory than primary skin-tight plaster.

The authors are enthusiastic about the method of cast traction in the prevention of deformity and osteomyelitis in compound fractures of the tibia and fibula.—*E.D. M., M.D.*

OCULAR NEUROSIS. A. M. G. Campbell and A. G. Cross. *The British Journal of Ophthalmology*, Vol. 28, pp. 394-402. London. August, 1944.

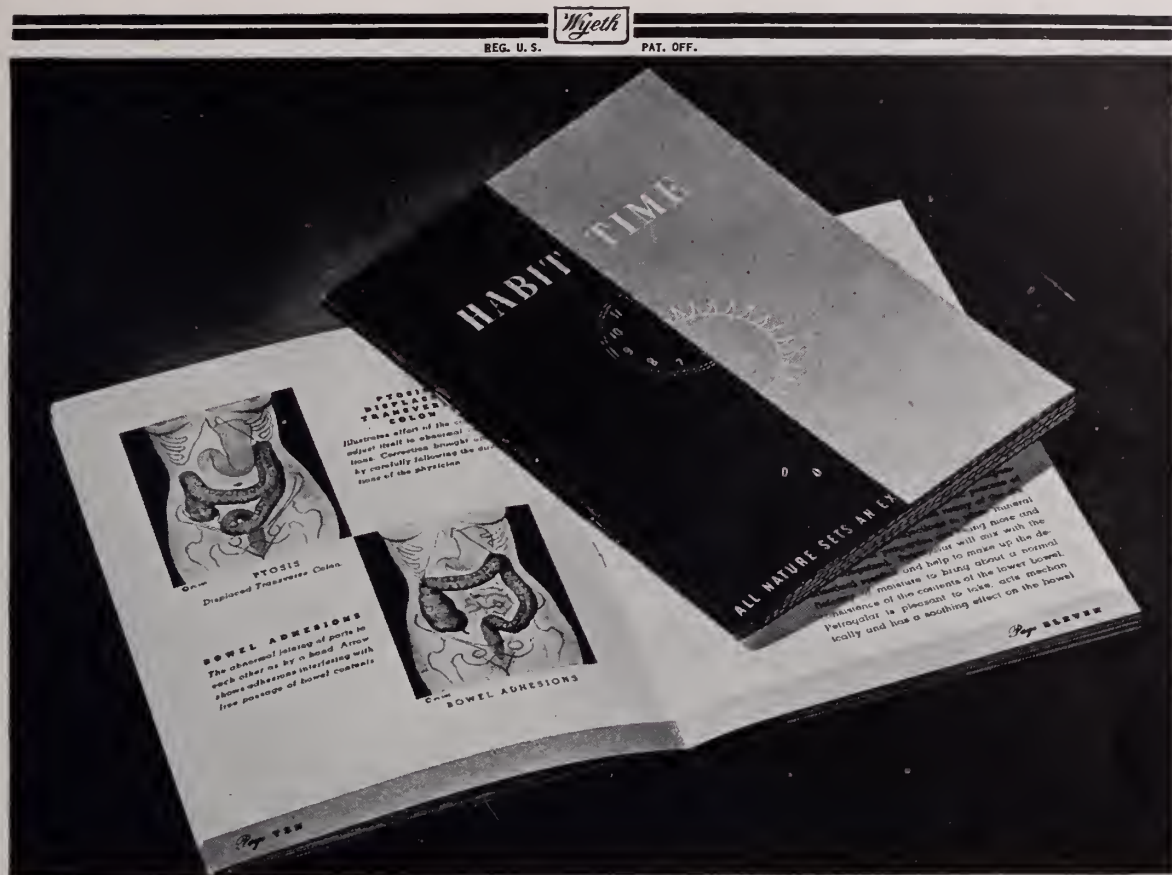
Ocular symptoms may exist in the absence of any organic lesion of the eyes, or may appear to be of a severity which is disproportionate to the pathological condition. Cases showing these symptoms are neurotic in type and are particularly numerous in wartime. The authors state that this condition is very frequent on the British Isles, where about 34 per cent of the cases of eye complaint is of psychological origin among members of the Armed Forces.

A history of previous nervous breakdown in the patient or his family is often present, and childhood traits of neurotic origin may be reported. Unhappiness in childhood and parental strife may also form a background. The occupation, climate, and contentment of the patient in his surroundings are important factors. Those who work in underground rooms commonly complain of ocular strain, which they attribute to bad lighting, though the illumination may be very good. Men who

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believe that they have "weak eyes" often manifest ocular anxiety symptoms as a result of a conviction that the heat and glare of the tropics will have adverse effect on their vision. Exposure to wind and weather may lead to the development of neurotic symptoms. The eyes are among the most usual organs of the body to be involved in the manifestations of neuroses because everyone is sensible of their importance in the living of a normal life. Separation from home and family and the inability to deal adequately with domestic situations may cause ocular anxiety symptoms.

Hysteria and anxiety states are prone to occur after head injuries and functional amblyopia is found not infrequently. Organic damage of the globe and temporary or permanent paresis of ocular muscles may be the result of accompanying injuries.

Flying and the strain which it may entail is an important factor in the production of ocular neurosis in all members of aircrew, who depend for their very existence on the continuing efficiency of their eyes under the most trying conditions. A pilot who begins to lose confidence and judgment in landing or in formation flying is apt to blame his eyes and not his mental make-up.

The failure of vision varies in degree from complete blindness in both eyes to a mild defect in one eye. The field of vision is usually contracted and it may be irregular. Eye-ache, eye-strain and tiredness of the eyes are common complaints in neurotic patients. The pain is frequently exaggerated, and they rarely disturb sleep. There may be also photophobia and excessive blinking, but there is usually no abnormal conjunctival congestion. Diplopia is a common complaint; if present at the time of examination, it is frequently found to be due to a deficiency of convergence. It should be emphasized that cases of neurosis are essentially polysymptomatic and that two or more of the above symptoms usually occur in the same patient. Symptoms tend to be contradictory, and signs to be irregular, as compared with organic conditions.

The treatment of such cases depends on how much value reassurance of the patient will have in clearing up his symptoms, and will only be really effective in a patient whose basic personality is sound. The prognosis of cases where real fear of disease exists is good because careful examination and re-assurance often cures them. Where the conflict is deeper and is bound up with various fears and troubles intimately connected with Service life the prognosis for future service is poor. A large number of these cases are capable of living a useful life under civilian conditions.—*M.D.II., M.D.*

A METHOD FOR FUSION OF THE WRIST. Paul C. Colonna. Southern Medical Journal, Vol. XXXVII, page 195. 1944.

Indications for fusion of the wrist include: chronic inflammatory lesions involving the wrist joint, tuberculous or non-tuberculous, that have caused the wrist to assume a flexed attitude; spastic paralysis with marked flexion deformity of the wrist; conditions following infantile paralysis in selected cases; and severe traumatic arthritis. In some instances muscle transplantation of the flexor muscles of the wrist into the extensors may be desirable preceding fusion. The operation is not done generally before epiphyseal closure is shown by roentgenogram, at sixteen to eighteen years of age. If fusion becomes necessary before this age period, operative closure can be effected.

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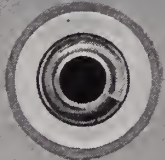
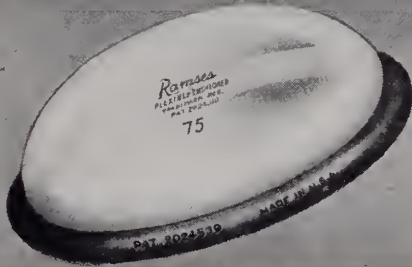
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wrist. The graft is split longitudinally with an osteotome and one half is fitted, marrow side down, into the denuded bed in the wrist joint. The other half is sometimes used for chips, to be packed in around the graft.

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VITAMINS IN OTOLARYNGOLOGY. H. B. Perlman. *The Annals of Otolaryngology and Rhinology and Laryngology*, St. Louis, Vol. 3, pp. 27-273. June, 1944.

There is now a widespread interest in the use of vitamins. The doctor and the layman are exposed equally to the untoward effects of advertisements and inaccurate information.

Vitamin A deficiency produces xerophthalmia and night blindness in man. In reviewing the clinical picture from reports of these cases and postmortem findings there is very little evidence of ear, nose or throat pathology. An occasional report of metaplasia of the bronchial and sinus mucous membrane appears in the autopsy findings.

Vitamin B1 or thiamine deficiency produces a disease called beri-beri. The clinical picture is that of multiple neuritis, but in the clinical and pathological reports of these cases otolaryngological signs are singularly scarce. Furthermore this vitamin may be synthesized in the human intestinal tract.

Nicotinic acid deficiency causes pellagra. Ulcerations in the mouth and glossitis are the principal otolaryngological signs. A dry esophagitis with ulcers was also present in a number of pellagra patients. Often associated with this deficiency is riboflavin deficiency, another vitamin B fraction. Inflammation of the lips and ragades about the corner of the mouth and nose appear to be its principal signs. The mouth ulcers seen seem to become infected with Vincent's organisms and respond to nicotinic acid therapy.

Vitamin C or ascorbic acid deficiency may go on without producing any other symptoms but loss of weight. Low ascorbic acid has been found in a few cases of gingivitis at the dental clinic, one or two patients having irritations from dentures. These have responded to ascorbic acid therapy. No other otolaryngological sign has been observed.

Vitamin D deficiency produces the clinical picture of rickets. Again no otolaryngological signs are common to this deficiency state. No other known clinical vitamin deficiency states are known although the tocopherol of vitamin E appear to be concerned with the reproductive and nervous functions in animals and vitamin K is important in the formation of prothrombin.

Criteria for defining known deficiency states in man are still in the process of formulation. Until these criteria are established the subclinical vitamin deficiency states cannot be seriously considered. In the otolaryngological literature a number of articles have appeared in which the author has attempted a correlation between vitamins and the diseased states. Yet, in none of these was the evidence for a vitamin deficiency state convincing. Neither were the therapeutic results conclusive.

In contrast to many poorly controlled clinical studies the controlled animal experiment and the biochemical studies continue to bring new light on the physiology of the vitamins and suggest possible ultimate application to otolaryngology. However, extreme caution should be exercised in transposing the results of vitamin experiments on animals to the clinic.

The use of vitamins for a transitory pharmacologic effect — as, for example, producing vasodilatation with nicotinic acid — may be mentioned only to point out that it is not directed towards correcting a specific deficiency state. One cannot expect to relieve a long standing pathological process by inducing a non-specific pharmacologic effect lasting only a few hours. Only changes in transient symptoms may be expected by such treatments.—M.D.H., M.D.

"STRAIN OF RIGHT RECTUS MUSCLE SIMULATING ACUTE APPENDICITIS." E. Dean Babbage, C. W. McLaughlin, Jr., and R. L. Fruin. *War Medicine*, Vol. V, page 280. May, 1944.

Various conditions affecting the musculature or the skeletal structures of the body may produce visceral symptoms. A most careful examination may be required in order that the correct diagnosis can be made. The particular syndrome of pain in the lower abdominal quadrant, produced by strain of the rectus muscles, has rarely been recognized in civilian practice.

The authors of this article have emphasized the difficulty of differentiating between a strain of the right rectus and acute appendicitis. The problem is made more acute by the fact that both conditions usually occur in young and active individuals. They have reported a series of 141 patients with strain of the rectus abdominis. The cases were collected, over a period of approximately nine months, in a large naval training station. Injection of a 1 per cent solution of procaine hydrochloride into the right rectus was suggested for all patients in whom acute appendicitis could not be excluded by the history or by clinical examination.

The procaine solution relieved the pain, if the primary pathology was in the abdominal wall, but failed to do so in acute appendicitis. Rest in bed proved to be the only satisfactory treatment for the patients with strain of the rectus muscles; the average stay in the hospital was five and eight-tenths days.

Hematomata of the right rectus abdominis muscle were common in the series, but aspiration failed to withdraw more than one or two cubic centimeters of blood. The condition required at least two weeks of rest in bed in the hospital for clinical recovery, and absorption of the hematoma required many weeks, after the patient had been discharged.—E.D.M., M.D.

"SPONDYLOLISTHESES. ANALYSIS OF FIFTY-NINE CONSECUTIVE CASES." Guy A. Caldwell. *Annals of Surgery*, CXIX, 485, 1944.

Low-back pain may result from a defect in the neural arch even though slipping cannot be demonstrated. On the other hand, such defects may not cause symptoms, even though marked slipping is present. Because of these variations, it is difficult to evaluate the effects of treatment.

In none of the series of fifty-nine cases was the displacement sufficient to permit its presence to be determined by inspection or palpation. The diagnosis, therefore, depends upon roentgenological examination, unless the deformity is great. Three views are recommended: (1) a direct antero-posterior; (2) a true lateral focused on the fifth lumbar vertebra; and (3) an anteroposterior view of 35 degrees, with the rays directed toward the head and centered between the sacrum and the fifth lumbar vertebra.

The major displacement is found to take place at an undetermined age, but it seldom occurs in adult life. It is believed that further slipping does not explain the symptoms which probably result from progressive narrowing of the disk space, and from proliferation of bone in the vicinity of the intervertebral foramina. In middle-aged persons not engaged in heavy labor, the symptoms usually are relieved by back supports, physical therapy, and postural exercises. Younger patients may require operative fusion, but it probably would suffice to confine the area of fusion to the lumbosacral articulations. When sciatic pain is associated with spondylolistheses, the nerve roots should be decompressed, either by removal of the encroaching bone or by the removal of a protruding disk. Theoretically, it might be best in certain cases to remove the neural arch and the inferior articular processes. Liberation of nerve roots without fusion of the articulation or bridging of the defect is to be supplemented by low-back support and postural exercises.—E.D.M., M.D.

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JAEGER, A. S.
Jl. *Indiana State Med. Soc.*
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ROBERTS, H. K. et al.
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Blaine.....	Virginia Curtin, Watonga	W. F. Griffin, Watonga	
Bryan.....	W. A. Hyde, Durant	W. K. Haynie, Durant	Second Tuesday
Caddo.....	C. B. Sullivan, Carnegie	P. H. Anderson, Anadarko	
Canadian.....	P. F. Herod, El Reno	A. L. Johnson, El Reno	Subject to call
Carter.....	J. L. Cox, Ardmore	H. A. Higgins, Ardmore	Second Tuesday
Cherokee.....	P. H. Medearis, Tahlequah	W. M. Wood, Tahlequah	First Tuesday
Choctaw.....		E. A. Johnson, Hugo	
Cleveland.....	Iva S. Merritt, Norman	O. M. Woodson, Norman	Thursday nights
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Cotton.....	G. W. Baker, Walters	Mollie F. Scism, Walters	Third Friday
Craig.....	Lloyd H. McPike, Vinita	J. M. McMillan, Vinita	
Creek.....	C. R. McDonald, Mannford	Philip Joseph, Vinita	
Custer.....	T. A. Boyd, Weatherford	W. H. Smith, Clinton	Third Thursday
Garfield.....	P. W. Hopkins, Enid	John R. Walker, Enid	Fourth Thursday
Garvin.....	Marvin E. Robberson, Wynnewood	John R. Callaway, Pauls Valley	Wednesday before Third Thursday
Grady.....	Roy E. Emanuel, Chickasha	Rebecca H. Mason, Chickasha	Third Thursday
Grant.....	I. V. Hardy, Medford		
Greer.....	R. W. Lewis, Granite	J. B. Hollis, Mangum	
Harmon.....	W. G. Husband, Hollis	R. H. Lynch, Hollis	First Wednesday
Haskell.....	William Carson, Keota	N. K. Williams, McCurtain	
Hughes.....	H. A. Howell, Holdenville	Imogene Mayfield, Holdenville	First Friday
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Jefferson.....	F. M. Edwards, Ringling	J. I. Derr, Waurika	Second Monday
Kay.....	Dewey Mathews, Tonkawa	G. H. Yeary, Newkirk	Second Thursday
Kingfisher.....	A. O. Meredith, Kingfisher	H. Violet Sturgeon, Hennessey	
Kiowa.....	J. P. Braun, Hobart	William Bernell, Hobart	
LeFlore.....	Neeson Rolle, Poteau	Rush L. Wright, Poteau	
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Mayes.....	S. C. Rutherford, Locust Grove	B. L. Morrow, Salina	
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McCurtain.....	J. T. Moreland, Idabel	R. H. Sherrill, Broken Bow	Fourth Tuesday
McIntosh.....	Luster I. Jacobs, Hanna	Wm. A. Tolleson, Eufaula	First Thursday
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Tillman.....	W. A. Fuqua, Grandfield	O. G. Bacon, Frederick	
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NUMBER 5

The Responsibility of the Physician In Preventive Proctology

ELLIS MOORE, M.D.

OKLAHOMA CITY, OKLAHOMA

The point I want to bring out in this short paper is the fact that we, as doctors, should pay more attention to our patients regarding their ano-rectal complaints.

The unpleasantness of a task is hardly an excuse for its avoidance, or an indication that it has no value. To some physicians it has been a matter of boasting that they cannot be bothered with "rectal cases," to others it has been a matter of regret. A physician should encourage those afflicted with rectal disorders to present themselves as early as possible and to teach them to be unashamed. The laity neglect their condition because they do not realize its significance and because they possess a sense of modesty which really should not be considered false.

Much literature (much too much of its kind) has been circulated in the years past. Many of the articles have been fundamentally sound. Also in some textbooks is given dependable material based on dependable experience. On the other hand, a great deal of what has been published has no value and is productive of harm. There are many so-called manuals which deal with the treatment of hemorrhoids. Often they are short and easy to read and some present alluring schemes and an easy, painless way out.

Many people fear medical attention, especially of the ano-rectal parts. They have learned to fear from those who have had similar conditions and have sought aid. The physician should not wonder that they turn to the popular cures advertised in the journals, circulars and newspapers. They see a refuge in the glowing descriptions of the various "painless pile dissolvents" and cures for

fistulas, fissures, papillae, prolapse and pock-ets, without the knife.

THE PATIENTS COMPLAINT AND ITS SIGNIFICANCE

Buie claims that the physician makes a mistake in handling the simpler types of ano-rectal disorders when he minimizes the significance of the disease. In the first place, the problem is more significant to the patient and he may immediately regard the physician with suspicion and besides he is disgusted later when a sickening, throbbing pain sends him to bed. Then his disillusionment is complete if the wound becomes infected and he loses days and possibly weeks before he can return to work.

A patient may believe he has hemorrhoids and grounds for his belief may be that he suffers with any one of a combination of the following conditions: backache, constipation, pain in the pelvis, fatigue and insomnia. The misfortunes of such an individual may be increased when hemorrhoids are found and removed without further search for the cause of the trouble. However, it may never occur to the patient that when his back still incapacitates him that it is his statement which implanted in the doctors mind the thought that the hemorrhoid might be the cause of the backache.

Patients may present themselves with a complaint of hemorrhoids. Some have them and some do not. Both types may arrive at their conclusion because of the presence of blood, and the physician is unpardonable who prescribes laxatives, ointments or suppositories, without first making the proper investigation. Even if the patient is examined

superficially and is found to have hemorrhoids and in profusion, he should not be sent away until it has been determined, when possible, if a new growth exists in the upper recesses of the rectum or the lower sigmoid.

The physician should be on guard for the case in which a troublesome frequency of stool accompanied by the discharge of blood and pus is associated with a carcinoma of the rectum or the sigmoid. We physicians well know that a patient who has rectal disease will defer treatment as long as possible. This is one of the chief reasons why proctologists are so handicapped in their attempts to deal with the cancer problem. Although pain, bleeding and protusion figure prominently in the accompaniment of hemorrhoidal disease, they are not always productive of enough inconvenience to cause undue concern. It is not surprising to find that in the Mayo Clinic that 32 per cent of the patients knew of their trouble for 10 years and 80 per cent allow one year at least to lapse before coming in for examination. Buie thinks it should be strongly urged that all patients who have some symptoms referable to the rectal outlet should be considered to have carcinoma until it is proved that such a lesion does not exist.

One of every 17 patients who come to the Mayo Clinic complaining of rectal trouble has carcinoma of the terminal bowel or anus and one of every four of these patients who have carcinoma have received treatment for some other supposed rectal condition during the period of his chief illness, the carcinoma remaining undiscovered. This failure is due to the attitude of the two chief parties concerned, namely; the physician and the patient. Obviously, it would be difficult to convince the patient that as soon as he notices any peculiarity of the function of the bowel to consult his physician. But the moment a patient is willing to present himself for examination because of some disorder pertaining to the function of the anus, rectum or colon, he is entitled to the most careful attention and a proctoscopic examination.

A physician should encourage those afflicted with rectal disorders to present themselves as early as possible and to be unashamed. They should be instructed of the painlessness of early carcinoma and the meaning of the passage of blood before, during or after defecation. Only in this way will it be possible to lessen the period of uncertainty which is so costly and which many patients will avoid if they know how. They often fear medical examination and surgery and it is lamentable that such fears are well founded. They have learned the truth from their friends who have had experience from charlatans advertising in journals, periodicals and newspapers.

CONSTIPATION, HEMORRHOIDS AND LAXATIVES

The proper function of one machine cannot always be considered a criterion of the normal functions of all. Some people are normally fat while others are normally thin, and many people make a great mistake when they attempt to make their figures fit the weights and dimensions of some published chart. It is like this with the activities of the colon. Thus, in some individuals it is considered normal to have one evacuation daily, others it is thought to be quite normal to have one action every second or even third day. I well remember a classmate, now in military service who always was quite well and had an evacuation each Wednesday. I haven't heard from him lately, but the chances are he has changed this habit to several BM's daily and has caught up with bowel habits.

On the other hand, there are individuals who can be considered who have two to three stools daily. A very prominent druggist in Oklahoma City has had five stools daily for over 30 years. He considers himself perfectly normal. So that, in taking histories, it should be first ascertained what is the regular normal bowel habit for that particular individual, or what it was before he considered it necessary to seek medical advice. Then the physician should proceed to find out when and in what manner this habit has been changed.

It is claimed that the use and misuse of laxatives is probably responsible for the development of hemorrhoids as frequently as any other single factor. There are thousands of patented remedies the baneful effects of which cannot be over-estimated.

CLEANLINESS IN HEALTH AND DISEASE

If it were possible, it would be quite profitable to establish a routine of personal cleanliness in regard to the care of the rectal outlet. Probably healthy tissues are able to withstand any effect which might be produced by constant exposure to filth of this type, but it cannot be denied that when tissues are subjected to any strain which is sufficient to produce solution of their continuity, they will be rendered more vulnerable and become more likely to succumb to invasion by micro-organisms.

Much has been said about active therapeutic measures for ano-rectal conditions. Personally, I like to prescribe the simpler measures, those which would bring the quickest relief at the least expense to the patient and permit the tissue to resume its normal function. In such cases, heat and hot packs and rest are advisable. Low hot water irrigation has been prescribed by many proctologists. Following these procedures, the pa-

tient should report each day for a topical application of some medication to the ano-rectal surface. All medical types of treatment should be accompanied by suitable examination in order to determine the response to treatment and to alter the character of same.

Physicians should not follow old-fashioned plans, diagrams and schemes without regard to the problems involved in any individual case. For example, it has been said that hemorrhoids develop in three main groups: so many on the right, so many on the left of the outlet. Also it has been said that hemorrhoids should be removed in groups, leaving a certain amount of tissue or strips of mucous membrane to prevent stricture. To a certain degree part of the above is true, but the operator should not try to hold himself and the operative field to a definite fixed pattern. There must be a certain flexibility of the scheme of the surgery to fit each individual case.

It should be understood that by careful technique and the proper regard for sound principles in the care of infected wounds, all of the hemorrhoid can be removed without producing any distortion or disturbing the function of the parts. Following a properly performed hemorrhoidectomy, hemorrhoids

will not recur and it is only when all the hemorrhoid has not be removed that they do recur.

The surgeon's fear of causing stricture is one reason why in some cases of hemorrhoidectomy, the operation is not complete, and when an operation on some of the more complicated types of hemorrhoids is considered, it is easy to understand why inexperienced persons should entertain this fear. However, experience has proved that such fear is unfounded if the operation is properly performed and if the parts remain in place as they were at the conclusion of the operation, undisturbed by sloughing which complicates wounds which do not receive proper attention.

Generally speaking, the medical profession has discharged well its duty to the public. Nevertheless, the boastfulness of some physicians that they cannot be bothered with rectal cases and they they are only regrettable, is to be condemned. Those physicians are unworthy of the esteem given them.

As long as some members of the profession are willing to pass lightly over rectal problems, they may expect those who employ unethical methods in medical practice to flourish.

Survey of Extraocular Motor Anomalies

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The steady progress in the science of medicine represents an aggregate of the contributions from its many related fields. In most of these fields a gradual increase in knowledge occurs without particular notice from the profession as a whole, in fact, developments in certain branches of a specialty may occur without making a deep impression on the specialist body. This lag in the dissemination of information usually provides ample time for the critical evaluation of new procedures so it is not an unmixed evil. However, the unrestrained publicity occasionally accorded to innovations in medicine frequently places the physician in a position of apparent ignorance of scientific facts. Certainly new procedures should be carefully appraised and shown to be definite improvements before they are recommended for adoption. A brief survey of extraocular mo-

tor anomalies in respect to diagnosis, prognosis and treatment, will help to establish our position in this field in accordance with modern, scientific thought.

Disturbances in function of the extraocular muscles are commonly divided into the "heterophorias" and "heterotropias"; the prefix "hetero-" being the general designation which is replaced by the prefixes "exo-", "eso", and "hyper" to indicate respectively, the deviation of the visual axes laterally, medially or in the vertical plane. The "tropias" designate the cases of obvious or manifest squint (strabismus), and the "phorias" comprise those tendencies to deviation which have not become manifest. There is no sharp distinction between heterophorias and heterotropias. Frequently a heterophoria progresses until it becomes a manifest deviation, or a squint may gradually assume an ap-

pearance of normality. Actually, the division is a convenient separation of two large groups which present some slightly differing factors in symptomatology, prognosis and treatment, that make their separate consideration more practical. For instance, heterotropias seldom give rise to any serious symptoms, while heterophorias frequently have distressing complaints of headache, drowsiness, burning sensations in the eyes and lids, nausea and other reflex nervous symptoms. The incidence of heterophorias is large, comprising a substantial percentage of patients with subjective eye complaints, while the incidence of actual strabismus is relatively small. Heterophorias are often relieved by the correction of refractive errors or the use of orthoptic methods, with surgical treatment necessary in only the most intractable cases, while surgical measures play a major role in the treatment of heterotropias.

The causes of dysfunctions of the extraocular muscles are many and varied. Etiological factors of ocular origin include refractive errors of any kind but usually of large amount, anisometropia and defective fusion sense. Systemic factors include acute or chronic infections, vascular disorders, toxic states, diseases of the central nervous system, poisonings, trauma, and metabolic disorders such as hyperthyroidism and diabetes. The lesion itself may be a primary degeneration, exudate, tumor, hemorrhage or other vascular change. Congenital causes also include abnormal muscle structure or attachment to the globe. The type and location of the lesion decides the nature of the onset and course of the disability at first, but secondary factors, such as the patient's reactions in an attempt to function as well as possible, determine the ultimate course. The treatment of the etiological factor is of prime importance, but since the damage to the ocular system is frequently permanent, the primary goal is the restoration of the normal, binocular function of the eyes.

In all branches of medicine we find that accurate diagnosis is a prerequisite for successful therapy but in no instance is this so invariably true as in the management of extraocular muscle anomalies. An analysis of each case according to the principles outlined by Dr. Alexander Duane is necessary in order to obtain a clear picture of the functional pathology. The essential steps are:

1. Recording of a complete history of the onset and development of the trouble, noting previous diagnoses, and treatment, associated illnesses and relevant family history.

2. Recording of visual acuity. Do a careful refraction, using cycloplegia after the preliminary muscle examination has been done. Do not neglect determination of the near

point of accommodation and the near point of convergence (Pcb).

3. Check excursions in all fields.

4. Use of the screen or cover test for distance, with and without glasses. This test is easily accomplished by rapid, alternate occlusion of each eye by a piece of cardboard while the patient fixates on a small light at twenty feet. This procedure interrupts fusion and any latent tendency to deviation is rendered manifest by movements of the eye to recover fixation as they are uncovered. The stopping of this movement by the interposition of loose prisms held before either eye, measures very accurately the amount of deviation. Lateral or vertical deviations can be measured simultaneously. Other tests are necessary only when there is lack of central fixation or the patient is too young for cooperation. The Hirschberg method of judging the displacement of corneal images is valuable in these cases.

5. Measurement of prism divergence and prism convergence.

6. Use of the cover test at fourteen inches, with and without glasses in the primary position and the six cardinal directions of gaze in order to check the action of each pair of muscles in their main fields of action. These findings are charted on different occasions. When errors are eliminated, a study of this chart with the associated findings will establish the diagnosis.

7. Use of the screen comitance test, to study under and over-actions of the muscles in the six cardinal directions. These are known as secondary deviations.

8. Diplopia plotting which serves as a subjective check of previous findings.

9. Estimation of the grade of fusion if any.

An additional step which is quite important is checking for anomalous retinal correspondence, a condition in which an image is projected from an area of the retina adjacent to the macula to fuse with the image of the non-squinting eye.

Simple checking of the amplitude of the ocular excursions seldom shows any limitation of motion in the fields of action of the ocular muscles, since only a very small portion of the usual strength available, is necessary to rotate the eye through its full excursion. Examination of the muscles in pairs of "yoke" muscles with associated actions, allows a comparison of their relative strength in their main field of action when fusion is broken by means of the cover test. The same amount of stimulus goes to each muscle in the attempt to maintain the eye in a position where it is fixing on the point object. Naturally a paretic muscle cannot hold an eye in

position with this inadequate stimulus if fusion is broken, so it will lag under cover. The amount of the deviation is measured with loose prisms. This procedure which is sufficient for identification of the paretic muscles is not sufficient to determine the proper treatment. A study of primary and secondary deviations and contractures, the fixing eye, the refractive error, the Pcb, and the general evaluation of the patient is necessary before proper therapy can be outlined.

The choice of eye for fixation may make a wide variation in the clinical picture in two patients with apparently the same diagnosis. If the non-paretic or normal eye is chosen for fixation, the paretic muscle in the affected eye is unable to balance the pull of its antagonist, which draws the eye into an abnormal position. Thus an eye with a paretic superior rectus is deviated downward if the sound eye is the fixing eye. Correction of this deformity is by shortening of the affected muscle. However, if the paretic eye is chosen for fixation, which is a common occurrence, an abnormally strong stimulation of the paretic muscle is necessary to balance the eye in the primary position. The associated muscle in the normal eye also receives this excessive stimulation and rotates the normal eye to an abnormal position. In the case of the paretic superior rectus this consists of an over-action of the inferior oblique of the normal eye producing a hyperphoria or tropia which is greatest in the upper nasal field. Experience has proved that functional correction of this deformity is best accomplished by tenotomy of the inferior oblique which is receiving the excessive stimulation. This may seem a strange situation to one unacquainted with the problem, however, it does not violate that fundamental dictum of muscle surgery, to always operate, only in the field of action of the affected muscles.

The visual acuity is a secondary factor which exerts a profound influence on the choice of treatment. Despite the vigilance of intelligent people, many strabismus cases in children are neglected until irreparable loss of vision has occurred as a result of disuse. There is no possibility of attaining binocular vision or developing fusion unless the poorer eye has a vision of at least 20/65. Complete, constant occlusion of the good eye over a considerable period of time is the only way of restoring vision to an amblyopic eye, and naturally it is the first step in treatment where amblyopia is present.

A secondary factor frequently overlooked is anomalous retinal correspondence. Although it is possible and in many cases, probably that normal retinal correspondence may develop spontaneously after surgical alignment of the visual axes, the early recognition and proper treatment of this condition will

undoubtedly prevent many a therapeutic failure. Abnormal correspondence exists in from 40 per cent to 60 per cent of heterotropias.

The classification of muscle imbalances into paralytic and non-paralytic groups also helps in the analysis of a clinical problem. Paralytic imbalances show an unequal amount of deviation in the various fields of action indicating that some muscles are affected and some are not. This places the causative lesion in the individual muscle or its motor nerve, producing a variable degree of paresis in the muscles affected. If the fourth or sixth cranial nerve is affected only the superior oblique or the external rectus show evidence of dysfunction, but if the third nerve is affected, any or all of the muscles it supplied (levator, superior rectus, internal rectus, inferior oblique or inferior rectus) may show varying degrees of dysfunction. The non-paralytic group includes dysfunctions of the powers of convergence, divergence and sursumvergence. These are the so-called dysjunctive actions in which "yoke" muscles function dysjunctively instead of together. Brain centers which control these actions are generally granted by neurologists, although their definite location is still unknown. The etiologic factor evidently affects these centers primarily.

Convergence anomalies are characterized by abnormal near findings, divergence anomalies by abnormal distance findings, and anomalies of sursumvergence by vertical imbalances which remain constant in all fields. They are generally known as concomitant deviations, or when manifest, as concomitant strabismus. In order of relative occurrence they are convergence insufficiency, convergence excess, divergence excess, divergence insufficiency and hyperphorias or anomalies of sursumvergence. A mixing or merging of these conditions with each other and coexistent paralytic anomalies frequently occurs and requires keen discernment to identify the primary condition.

According to Dr. James W. White, convergence insufficiency occurs in approximately 40 per cent of all cases presented for refraction. There is no doubt that it is an extremely common condition. It is usually associated with subnormal accommodation and presents many distressing, subjective symptoms of asthenopia such as headache, burning of eyes and reflex nervous symptoms. The etiological factor is usually some systemic condition. An exophoria or esophoria of one or two prism diopters may be noted for distance, but for near the exophoria or tropia exceeds seven prism diopters. The Pcb is greater than 90 mm. and prism convergence is below normal. The cooperation of an in-

ternist to treat the systemic factors involved is usually necessary. Orthoptic treatment is very effective. The use of prisms in glasses is not recommended except occasionally in the presbyopic correction for elderly people.

Convergence excess often manifests subjective symptoms, since the etiology is more often ocular than systemic and discomfort in use of the eyes is common. The esophoria or tropia is greater for near than distance and prism convergence is usually excessive. The deviation frequently becomes manifest, the strabismus being precipitated by some concurrent illness or trauma. Surgical treatment is often necessary in addition to full correction of refractive errors. Additions for near may be helpful but prisms in the lenses are rarely satisfactory. Orthoptic treatment which effects a dissociation of the convergence-accommodation ratio and reassociation using a synoptophore with minus lenses may prove helpful.

Divergence excess is probably due to a combination of ocular and systemic factors. It seems to occur frequently in young women. Prism divergence is excessive but the near point of convergence is normal. Correction of refractive errors or orthoptic exercises are seldom helpful, although Dr. LeGrand H. Hardy recommends the development of a compensatory convergence excess. Subjective symptoms are not marked. Occasional, manifest lateral deviations occur, with or without the patient's knowledge. The treatment of choice is surgical weakening of one or both external recti.

Divergence insufficiency commonly occurs in neuropathic individuals and ocular factors seem to have little influence. It is difficult to handle. There is an esophoria for distance greater than for near, with diminution of prism divergence. Attention to the general health is of primary importance, but relief is often obtained by orthoptic exercises which build up the power of prism divergence, even though objective improvement may be slow. Occasionally the use of prisms, base out, in distance glasses is indicated. Most cases eventually come to surgery.

Concomitant hyperphorias are fortunately rare. Nearly always an increase of the deviation in one of the fields can be detected which puts the condition under the paralytic classification, and usually simplifies the surgical treatment. Correction of refractive errors may control the disability, and occasionally vertical prisms are helpful. The subjective symptoms are marked, as a rule.

The prognosis in dysfunctions of the extraocular muscles naturally depends on the nature and extent of the involvement, but the following generalizations are permissible. In practically all cases of good cosmetic re-

sult can be assured; subjective relief and objective functional correction in a very high percentage. These results cannot be obtained by the use of one or two methods. Accurate refraction, careful surgery and orthoptic methods are all necessary for different phases of treatment. Orthoptics includes all procedures other than surgery which are designed to develop, or restore the normal, coordinated binocular functions. For its specific purposes in diagnosis and treatment, nothing will take its place. In spite of the recognition of its valuable place in ophthalmology for the past two hundred years, the difficulty in its practical application precluded its general use until the last few years. The present availability of many ingenious machines has promoted unqualified persons to cash in on the current publicity concerning eye exercises, and the subsequent misapplication of their therapy has had many bad results, particularly in cases of anomalous retinal projection, in which an existing defect is not only confirmed but made much worse by unskillful treatment. Those who advocate orthoptic exercises as the non-operative as opposed to the operative treatment of squint create much confusion concerning the role of a valuable therapeutic method. All methods are merely supplemental to each other and proper treatment depends on the critical evaluation of each individual case by a competent physician.

Orthoptics is probably best considered from the viewpoint of Dr. Lancaster, who states that it is not primarily a method of exercising the ocular muscles or a procedure designed to straighten the eyes but the teaching of a patient to use his two eyes together for comfortable, binocular vision. The emphasis in such training is the teaching of a skill in the use of unskilled neuromuscular coordination. The equipment, training and temperament necessary for the proper application of orthoptic methods may preclude its use by many individual ophthalmologists, but all should be willing to encourage the development of available facilities for its application in a scientific manner.

This brief survey of extraocular motor anomalies gives a birdseye view of the subject but necessarily omits many of the interesting clinical variations. Occasional statements may have appeared arbitrary but differences of opinion arising from different approaches to a problem form one of the most valuable phases of a review paper of this kind. A consideration of other's perspectives should always prove broadening, even if only to a slight degree. While it is often possible to obtain satisfactory results with many different approaches to a clinical problem, the

wise and conscientious ophthalmologist will utilize every facility available to secure the best possible results.

*The opinions or assertions contained herein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the naval service at large.

SPECIAL ARTICLE

Political Control of Medicine*

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The movement to socialize the practice of medicine began about twenty years or more ago when professors and students of Sociology, Social Economy and Welfare Work conceived the idea that the cost and distribution of medical care would have to be better equalized, if the standard of living in our nation were to continue to improve. Their idea was to introduce some compulsory plan by which every person would get complete medical, dental, hospital, and nursing care, including preventive medicine by paying a regular annual or monthly fee. The result, they argued, would be a very definite and rapid improvement in the national health and a subsequent disappearance of most of our social ills. A very kind and humanitarian idea, but these people failed to realize that there was a lack of other necessities which affected millions of Americans a great deal more than a lack of medical care. Sufficient food, for example, shelter, and steady jobs. Nor did they seem to understand that the very taxes necessary to support such a system of compulsory health insurance would deprive the poor of even more of these necessities of life. Furthermore, they disregarded the proven fact that in countries having compulsory health insurance, the people were actually less healthy than the American people, indicating conclusively that the lack of medical care is not the only contributing cause to all our social ills.

At that time the proposal met with considerable protest and since the idea was not nationally publicized, nothing further was done about it.

About ten years ago a certain group of politicians discovered the plan and apparently seeing in it enormous possibilities of political power, securely masked behind the great humanitarian name of Social Progress, began to introduce bills to Congress, attempting to regulate the practice of medicine by federal control. This definitely placed the matter in an entirely new category and it is this problem, the political control of medicine, which must of necessity interest us now.

The first bill of any consequence which came into Congress was introduced by Senator Wagner of New York, titled the National Health Act. The introduction of this bill significantly followed two other events, the much publicized prosecution of the American Medical Association for its alleged abuse of the Washington

Health Group and the equally well advertised National Health Council, which made the flat assertion that one-third of the people in the United States had inadequate or no medical care. This statement was promptly challenged by men both in and out of the profession all over the country. They also raised the question whether the needs of this limited group, some of whom may really need assistance, should be used as an excuse to bring the entire medical profession, the hospitals, and all others engaged in the care of the sick under the control of a Federal Bureaucracy. This bill was defeated.

In 1943 Senator Wagner, in conjunction with Senators Murray and Dingell, introduced Bill No. 1161, better known as the Social Security Bill, in which proposed politically controlled medicine made its appearance in an even more glittering and expensive form. It is doubtful if any proposed legislation has ever been quite so vicious and deceptive, or so destructive of human freedom and self respect.

Fortunately this bill did not pass, but we may expect its reappearance with ardent support by its sponsors and their friends in the administration including organized labor, long active in developing local medical service plans. Labor leaders have seized upon health as a means of strengthening the tie between Union and Union Member. Active endorsement of the Wagner, Murray, Dingell Bill by both the C. I. O. and the A. F. of L. which ordinarily have little in common, as well as by independent factions which refuse to affiliate with either, indicates that all see eye to eye when it comes to a National Health Program. These groups were not slow to make use of facts such as shown in a survey in California in which 72 per cent of all persons questioned in a state-wide poll, answered in some form or other that the cost of medical care was, in their opinion, too high. It does little good to question the public's judgment. The citizen selects Federal Medicine only because he thinks he can get scientific medicine no other way, and the labor leaders and politicians encourage this belief. What the public does not know is that Federally controlled compulsory Health Insurance cannot render the best and cheapest medical care.

It is our task to see to it that the public becomes acquainted with the facts so that it may be better able to make the right decision when the time comes.

In order to do this let us examine the medical care set-up in the Wagner Bill a little more carefully in order to see just what such plans would mean to the public.

This bill broadens the existing social security coverage

*Read before the Woman's Auxilliary of the Oklahoma State Medical Association; in Oklahoma City and Tulsa; the Blue Stocking Club of Oklahoma City; the Parent Teachers Association of Putnam Heights School in Oklahoma City; various other lay groups.

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by providing for payment of cash, permanent disability benefits to its beneficiaries. This would cover all persons included in the present Social Security plan, also farmers, servants, government employees, and professional people not now included. The system would be financed from a trust fund established by a six per cent employer and a six per cent employee withholding tax, or a total of 12 per cent of all the wages and salaries up to \$3,000 per year. The self employed would be required to pay 7 per cent of their estimated yearly earnings up to \$3,000 a year and certain federal, state and municipal employees, 3½ per cent. The estimated cost of the entire system was \$12,000,000,000. But that would not be all. The research director of the Insurance Economics Society of America estimated that the ultimate cost, when changes and corrections were made after the system was put into effect, would in all probability be 20 per cent of our national income or about \$12,000,000,000 a year. To the individual it would mean an increase of six times the existing one per cent social security tax, considering only the estimated and not the ultimate cost.

Thinking persons must of necessity question whether the social gains would in the end justify this stupendous expenditure. What would be the social gains? Can the national economy function smoothly and soundly under such a load? Does our history indicate that social betterment can be attained only through such expenditure and under government compulsion? And finally, what might be the ultimate social disadvantages?

It may be interesting to note at this point that statements have been made by several prominent men in our country, whose positions should make them authorities, indicating that powerful interests abroad want very much to see the United States enact a bill of this kind or at least its principal features, so that the United States could not have the competitive advantage which it otherwise might have. It is obvious that a nation burdened with taxes so that its business and industries cannot accumulate reserve capital for purchasing and development, is no threat to other impoverished nations whether through taxation or otherwise.

But what kind of medical care will the \$3,000,000,000 apportioned by the plan to the medical care of the nation give us? Scrutiny of the plan reveals that this \$3,000,000,000 would be turned over to the Surgeon General of the United States Health Service, an appointive office by the President, who becomes thereby the absolute czar or dictator of American Medicine, empowered to provide medical and hospital care for the 135 million people now living in the United States. True, he is to have an advisory board, but it is to be only an advisory board, it has absolutely no power to force the Surgeon General to do as it advises. He would have unlimited power to hire and fire all doctors for the plan, establish their rate of pay, determine the number of patients each doctor may serve, decide which doctors may specialize and in which field, hire and fire all major and minor officials. He would also be the sole judge as to which hospitals may provide service, direct the programs and curricula of the medical schools and choose the men who are to study in them. Can you imagine a juicier political plum?

Three billion dollars is an enormous amount of money. It is enough money to hire every doctor now practicing in this country at a salary of \$5,000 per year, to hire every bed in every privately owned hospital every day in the year at a rate of \$5 per day; to pay \$2.50 every day in the year for every bed in a government hospital (before the war); to spend over 250 million dollars a year for medicines and supplies and still leave 500 million dollars for the politically appointed office holders which the plan would require. The 48 million dollars a year estimated by the bill to be spent for medical education and research could at present assume the total costs of operating the country's 77 medical schools, subsidize 22 thousand medical students at \$100 a year and have 11 million dollars left for research.

Thousands of workers would be required to man the network of bureaus necessary to administer such a plan.

Mr. Winston Churchill sounded a serious warning when he said, "We must beware of building a society in which no one counts for anything except a politician or an official; a society where enterprise gains no rewards and thrift no privileges." We are in a fair way to become just such a nation when we consider that since 1939 the Federal Government is said to have increased its employees almost 50 per cent every six months. With more than three million civilian employees, exclusive of army and navy personnel, our Federal Government now has more persons on the tax payer's pay roll than the combined total of all the employees of all the 48 states, plus all the employees of the country's County and Municipal governments. Of these, 55 per cent are not directly engaged in the war effort. There are approximately 135 million people in the United States. Only a vivid imagination can figure to what staggering proportions the number of bureaus and employees would have to be increased to care for the medical, administrative and clerical needs of such a program. It is well to keep in mind at this point, that a bureaucracy is not established by a vote of the people, it is not responsible to the people for any of its acts, but it helps make up the group that takes advantage of the franchise regularly and conscientiously, in order to continue its very existence.

The real tragedy, however, lies in the fact that at the bottom of the long list of employees will be the doctor, responsible to a politically employed office force, at the beck and call of every call dispatcher. Just what kind of a man will be willing to place himself in such a position, or what young man will choose medicine as a profession under such conditions. Certainly not the kind we now have. The long period of preparation, the rigid standards of scholarship, character, and personality have automatically barred the less desirable men from profession. The long hours, the indefatigable devotion to duty and the unselfish interests in the patient do not attract anyone but a person of high ideals. Furthermore, the confidential relationship between doctor and patient would be completely destroyed. The public would lose the personal interest of the physician and that high quality of service that comes from the individual responsibility which the physician now carries in his professional relations. Imagine how it will be when the doctor works eight hours a day with Sundays off and time-and-a-half for overtime. And the doctor who has cared for you and your family for years may have no place for you on his panel. So you become patient P. 713 from district K, assigned to Doctor M. D. 36 for preliminary examination. If you require surgery you will be reassigned to Surgeon S. 57, who looks on you not as his old friend and patient, Mrs. Smith, but as patient No. 713, operation No. 4, and he hopes he will get through in time to get to lunch when the bell rings. Or perhaps you haven't had a very good day and would like the doctor to come by again, just to assure you that there is nothing to be alarmed about during the night, but according to your record which the doctor filled out and left after his call this morning, you had no unusual symptoms, you had no temperature, you had a very comfortable preceding night, so the call dispatcher doesn't think you need another call. The Doctor can't talk to you on the phone right now, since this is the time he has to make out his daily reports which have to be turned in before he can go to dinner. In that case you decide to call Dr. Brown who used to take care of you, he will come over you know, but when you call Dr. Brown you find that he has had to close his office; since so many of his patients have been taken over by the government doctors, he could no longer make a living as a private physician. He is sorry he cannot come for he is not allowed to see anyone but those patients on his panel. Patients are not allowed to choose just any doctor, for then a few of the popular ones would have too much to do and the others would be idle. All this may sound very amusing, but that is exactly what may happen under a plan of this kind. In England, for example, the choice of a doctor was left more or less to the patient with the result that a few of the doctors were so busy that a system of hurried diagnoses

and stereotyped prescriptions resulted, while the less popular doctors didn't make a living wage. This certainly is not calculated to raise the standards of medical efficiency or patient care.

But the most serious blow to the doctor's self respect would be the sacrifice of the patients confidence. Where he formerly sought advice, the patient would now demand service because he had paid for it in advance. There is a subtle difference between these two attitudes, though since it cannot be expressed in dollars and cents, few people will be able to appreciate it. If a doctor tells a patient he needs no treatment or medicine he will be suspected of loafing on the job. In Great Britain this developed in the working classes a strong craving for medicine, because when he got a bottle of medicine the patient thought something was being done for him. If the doctor prescribes a treatment that is distasteful to the patient, he is likely to be reported to the management as if he were an offending clerk at a post office window. Our citizens would eventually be paying dearly in heavy taxes to support an elephantine government structure for an increasingly poor grade of medical care by a greatly harassed doctor who must necessarily become a pure automaton under such a burden.

The general health and medical care set-up in the United States, though admittedly not perfect, is the very best in the world today. Our citizens have a much lower mortality rate, our record of contagious diseases is much lower, life expectancy is very much higher than in any comparable country in the world, and our infant and maternal death rate is lower than in any other country this size. Scientific research and medical discoveries have come out of the present system, and today the United States is the center of medical progress in the world. European countries under a system of government controlled medicine have become relatively negligible in their contributions to medical science.

By way of comparison let us see what has happened in England under the panel system from quotations from articles by English and American doctors who have made a study of their system.

"There is a continuous criticism that incipient diseases are not being detected. The sort of diagnosis which is given in many of the panel practices, is merely casual observation and nothing is done about it until the disease becomes more advanced, sometimes beyond the hope of repair."

"In England it is difficult for the panel physician to get all the facts from the patient, for the patient knows that the record made of his history and illness is inspected by the Insurance Commissioner of the Society. He is therefore guarded in his disclosures concerning himself contrary to his own interests. There are rigid restrictions as to the cost of the drugs and appliances, which hampers the doctor in his treatment and affects the comfort of the patient. Officials pry into details of the relationship which tends to lessen the patient's respect for the doctor.

"The chief flaw in a badly organized service, such as that which has evolved in this country during the last century, is lack of time for both the general practitioner and the consultant, in order to earn a living wage, are frequently obliged to undertake far more work than they can deal with efficiently in the hours at their disposal.

"Malingering has become a national evil in most of the countries where compulsory health insurance is in existence. Malingering may seem a small matter to the average person but it is an important matter to the busy doctor, is definitely damaging to the patient himself and to your pocketbook.

The affect on the voluntary hospital system, one of the greatest of American institutions, would be fatal. Hospitals would in effect become government hospitals or close their doors. Controlled by a Washington Bureau, they would become a political football and a prey to patronage and power. A look into any of our large City

or County Hospitals would erase any doubt as to the advisability of allowing hospitals to be run entirely by politicians.

Mr. C. O. Pauley, President of the Insurance Economics Society of America, who opposes the system because it will destroy all private insurance business, says, "The Government's efforts should be directed primarily at the causes of unemployment, accident and disease, and to the rehabilitation of those persons who have become impaired. It should be addressed primarily to the underlying causes for the conditions rather than placing the emphasis upon paying its citizens for being unemployed or sick. It should encourage its citizens to provide against such contingencies by education, insurance, and all means available, rather than fasten upon the whole American people a vast compulsory insurance system, the inevitable fore-runner of totalitarianism."

The legal, dental, engineering and nursing professions see in this plan a decided threat to their own professional freedom.

A system of paternalism has never improved a people, on the contrary, it has made the individual more dependent, less willing or capable of working and definitely more pliable in the hands of a political machine. After the war we will have about ten million young men, trained to hard work, taught to sacrifice, disciplined for service, returning to their homes to rebuild the America they have fought for. They will want security, the good old fashioned security of opportunity, not the paternalistic type of security based upon the despotic system they have fought against so bitterly on the far flung battle fronts. It would be the supreme tragedy of the nation's history, if these young men were completely ruined by a system of cradle to the grave benefits; all their fine courage smothered in a lazy man's paradise.

But who is it that needs medical care and isn't getting it? Aside from the rich who do not need to worry about the cost there are the indigent who, to a large extent, are provided with medical care along with their other forms of relief. Certainly it is not necessary to set up a 12 billion dollar program of medical care for them any more than it is necessary to set up a whole socialistic government in order to provide them with relief. But there are three classifications of people who do come under the medical expense program.

1. The large number in the middle and lower classes who are entirely self supporting until illness strikes. One serious illness can upset their budget for years.

2. Those who rather than accept a doctor's generosity or take advantage of public medical facilities, postpone medical care to their own detriment.

3. Families and individuals who indulge in all kinds of luxuries yet never have any money for medical care when the need arises. We have every sympathy for the poor who wish to maintain their self respect, yet in viewing this matter it is necessary to preserve a sense of proportion. No one ever heard of a grocer habitually reducing his prices to those little able to pay simply because people need food and haven't the money to pay, yet the doctors do it every day. Nor has anyone suggested that the state take over the farms and factories to provide food and clothing to everybody, merely to save those on relief the embarrassment of receiving free provisions. Everyone is entitled to the best food at the price he can afford to pay. And everyone is entitled to the best housing and clothing he can afford to buy. The trouble is that many people regard illness as an accident for which they are not to blame or which they could not foresee, and therefore they do not feel the obligation of their medical bills as they do the obligation to pay for their food, clothes, radios, etc. It is indeed paradoxical that a nation that spent 6 billion dollars in 1943 for intoxicating liquors, a 90 per cent increase since 1939; that smoked 160 billion cigarettes and vast amounts of other forms of tobacco, drank millions of gallons of soft drinks, ate tons of candy, cannot afford a doctor bill

several times a year. We buy everything from one extreme of necessity to the other extreme of luxury on the installment plan and pay for it. We fill the movie houses night and day, crowd the night clubs, gambling houses, play the slot machines, bet on the horses, support the prize fights, wrestling matches, ball games and what have you. This is the middle class Jones family with the middle class income, that goes completely bankrupt when it has a doctor or hospital bill to pay. It is the Jones family too that is not satisfied with anything but the best in hospital service and nursing care, so that when everything is over, even a very reasonable doctor fee is the straw that breaks the back of the Jones' financial status. Certainly a readjustment of values here would solve a great part of the problem, but that still leaves the first two groups who do need help. Yet, federally controlled health insurance with its implications of political control and cheapened medical care is not the answer.

The American Medical Association has long seen the need for a strong non-profit medical indemnity plan to spread the cost of medical care. It sees this type of pre-payment plan as a means of encouraging budgeting for care on the part of those self-supporting individuals who nevertheless find it difficult to pay their medical, hospital and dental bills, and who would make some provision for them if some plan were offered to them.

Contrary to the impression created by the Washington Group Health Association and the attendant Anti-Trust suit against the American Medical Association, organized medicine has not opposed any voluntary medical indemnity insurance. The medical societies of 38 states now have voluntary pre-payment plans now in operation, or are experimenting in that direction. Many of the county groups are working on changes aimed at making preven-

tive medicine and curative service available to all people, whatever their economic status. Such plans operate very much as does the Blue Cross Hospital Plan. A Blue Cross Hospital Policy may be purchased for as little as 3 cents a day, the cost of a daily newspaper or a movie a week. The subscriber has a free choice of the hospitals operating under the plan and a completely free choice of doctors.

For approximately the same cost per day one may become insured for medical care in the home, or in the doctor's office or in the hospital. The subscriber has a choice of physicians. The governing boards of such plans are made up of regularly licensed physicians, members of their respective County Medical Societies, and this means that the discipline and control remain largely in the hands of the medical profession. The plans are set up in each locality subject to the approval of the State Insurance authorities. The public may not realize the necessity of all this unless they know that private, unsupervised plans may mean absolutely unethical, inefficient, poor, but expensive medical care.

The various pre-payment plans are in the trial stage and every group is meeting daily problems that must be solved and then passed on to other groups. A plan so gigantic, with so many human elements involved will take a few more years to build. We have no illusions that the simple passing of laws will solve all the social ills of the human race. Nothing so close to our personal welfare can endure without long trial, experience, much planning and forethought. Until that time let us not be deceived into passing any laws that glitter with promises, but which take from us the very privileges of deciding what to do with and for our own bodies and entangle us in the web of a complete totalitarian government.

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By supplementing the diet with AMINOIDS*, the physician provides the nursing mother with sufficient protein for normal lactation and for optimal maintenance of her own reserve.

AMINOIDS is a protein hydrolysate containing the amino acids known to be in the source materials—beef, wheat, milk and yeast. Patients like it because it is pleasantly palatable and convenient to take in hot or cold liquids . . . milk, canned juices, broths, etc.

One tablespoonful of AMINOIDS provides nitrogen equivalent to 4 grams of protein as hydrolysate.

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A PROTEIN HYDROLYSATE PRODUCT

For Oral Administration



Pads of practical recipes incorporating AMINOIDS available to physicians upon request.

(1) De Lee, J. B., and Greenhill, J. P., *The Principles and Practice of Obstetrics* (1943), pp. 317-319.

*The name AMINOIDS is the registered trade mark of The Arlington Chemical Company.

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THE PRESIDENT'S PAGE

The beginning of a new year should, of necessity, have a very definite program, practical, workable and above all, one that is applicable to the needs of the year.

We submitted a four point program to the House of Delegates and the council for their approval, which was confirmed. No. 1—Public Education; No. 2—Post Graduates; No. 3—Post-War Planning; No. 4—A very close cooperation between the County and State Societies.

This can only be carried out by untiring efforts on the part of the State and County Societies, soliciting the support and help of all the heads of the Counties, securing speakers from laymen such as the Senators from every Senatorial District of our State and to the laity who are interested in health and welfare of the people of our State. A very close cooperation between the Oklahoma State Health Department, the Oklahoma Tuberculosis Association, the Oklahoma Cancer Association, the Crippled Children and the Maternity and Infants Department, welded together in a Speakers Bureau from the most enthusiastic and qualified speakers that we can secure, along with all the avenues of publicity, press, motion pictures and radio.

This page would not be complete without calling your attention to the very unusual success attained in the past years program. The professional fellowship between the State and County Societies, manifested in the Council meetings was most unusual. The unity of both was most inspiring. The success attained through the efforts of the Association, along with the Governor of our State's Health Program, succeeded in bringing to pass, legislation that had been sought for, and deemed necessary for many years.

The personnel of the State Medical School and the Health Department cooperating with the State Association and the Governor to such an extent that failure seems impossible. If we are to accomplish the things that are essential for the post-war area and hold our standards to the past years' level, we must, of necessity, depend on a unified front, well informed of their part in the program.



President.



V. C. TISDAL, M.D.
President

The JOURNAL of The OKLAHOMA STATE MEDICAL ASSOCIATION

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Manuscripts may be withdrawn by authors for publication elsewhere only upon the approval of the Editorial Board.

MANUSCRIPTS: Manuscripts should be typewritten, double-spaced, on white paper 8½ x 11 inches. The original copy, not the carbon copy, should be submitted.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space. Bibliography listing should follow this order: Name of author, title of article, name of periodical with volume, page and date of publication.

Manuscripts are accepted subject to the usual editorial revisions and with the understanding that they have not been published elsewhere.

NEWS: Local news of interest to the medical profession, changes of address, births, deaths and weddings will be gratefully received.

ADVERTISING: Advertising of articles, drugs or compounds unapproved by the Council on Pharmacy of the A.M.A. will not be accepted. Advertising rates will be supplied on application.

It is suggested that members of the State Association patronize our advertisers in preference to others.

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Address all communications to THE JOURNAL OF THE OKLAHOMA STATE MEDICAL ASSOCIATION,
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EDITORIALS

THE STATE BOARD OF HEALTH

With what we hope may prove to be an harmless compromise, the State Board of Health Bill has been signed by the Governor. If this Board functions as it should the doctors will be relieved of a lot of work through improved health and the people will save a lot of money which otherwise would have been expended for medical care.

Through the untiring efforts of certain members of the State Medical Association, the people have their protection and pocket their money without giving a moments thought to this strange phenomenon. They never stop to think that only doctors constantly work against their own material interests in order that the people they serve may have a greater store of health and happiness. In the State of Oklahoma the people must be taught what medicine, as a free enterprise, means to them. President Tisdal is committed to the task of educating the public. The members of the State Association should stand behind him with moral, intellectual and financial support. To let the people know the meaning of this new State Board of Health, and the other important health legislation including the appropri-

tions for the medical school should serve as a good beginning.

The citizenry of Oklahoma are greatly indebted to Paul Fesler, Executive Secretary of the Oklahoma State Medical Association, who worked day and night, in season and out of season in behalf of the above legislation. Much credit should go to Drs. Rountree, Tisdal, Osborn, Lowry and many other members of the profession who made sacrifices in order to contribute time and effort for the public weal.

In the Legislature the doctors and friends of the doctors who supported this legislation deserve a hand, not only from their constituency, but from all the citizens of the State.

THE COUNCIL AND THE HOUSE OF DELEGATES

The Council, having been well barbequed by the worthy President of the Association and the genial Dean of the Medical School, met at the State Association Headquarters from 9 p. m. until 12 midnight on Saturday, April 21. In spite of the relaxation so obvious on every face during the great outdoor party at Circle S Ranch, the members of the

Council assumed their obligations with a seriousness not surpassed by Sheriff Sleeper's blood hounds, as they nosed the footprints of the ostensible criminal at Circle S. By midnight they had all their serious problems up a cottonwood.

Facing a House of Delegates, streamlined by the Office of Defense Transportation, the Council is to be congratulated for having made it possible for the House of Delegates to pluck the Associations problems from the tree ready for judgment and commitment. This abbreviated House of Delegates manifested the usual wisdom in that they carefully weighed every question and left a record of which the Council, the full House and the Membership may be proud.

For confirmation of this, those who receive the Journal are requested to carefully read the minutes and Committee Reports as they appear in succeeding issues.

THE NEW PRESIDENT AND HIS PROGRAM

The induction of the new officers was climaxed by President Tisdal's brief inaugural address. His 4 Point Program is in line with the best traditions of medicine. It contains all the elements of a constructive, progressive, scientific program, well integrated with humanitarian purposes including lay education as a special interest. This program is designed to bring better medical service to the people and to give them a better understanding of this service and the importance of the present patient-doctor-God relationship and should have the hearty support of the profession and the people.

OKLAHOMA COUNTY MEDICAL ASSOCIATION LUNCHEON

The Oklahoma County Medical Society is due a vote of thanks for the luncheon provided at the Skirvin Hotel for the Council, the House of Delegates and guests. A thoughtful gesture, adding a needed social and gustatory aspect to the successful meeting—*Thanks* to the Oklahoma County Medical Society.

FEE SCHEDULE OF THE VOCATIONAL REHABILITATION DIVISION

With the approval of the Council, Dr. Clinton Gallaher, Chairman of the Medical Advisory Committee to the Vocational Rehabilitation Division, has submitted the following statement which commands the serious consideration of every member of the Association:

The Vocational Rehabilitation Division, an activity of the Oklahoma State Board of Education, has asked the Medical Advisory Committee to assist them in securing a sat-

isfactory fee schedule. In order that this schedule may be acceptable to the physicians of Oklahoma it has been suggested that the physicians of Oklahoma shall express their several opinions in regard to this matter. At present it is the intent to ask each physician who may be interested in or who may be asked to participate in this program to carefully scrutinize the tentative schedule and frankly criticize the same and offer suggestions for improvement if it is found to be unsatisfactory.

The Committee which represents the State Medical Association in this activity solicits your cooperation in the determination of the items of this fee schedule. There is no desire to ask any physician to perform any examination, to prescribe or to do an operation at any fee which is not acceptable to him. It is of some importance, however, to get as near unanimous agreement as possible.

Please speak out now—rather than to criticize later.

OUR SEVENTH OPPORTUNITY

Whether in foxholes or on the march, our men overseas are bound for victory. While their broken bodies are being bound by our doctors at the front, we must make sure that these brave men are well bonded by their doctors at home.

Don't let the Seventh War Loan Drive pass without buying your quota of bonds.

TRAILING THE DIABETIC

The January, 1945 issue of The American Journal of The Medical Sciences presents an important symposium dealing with 100 cases of diabetes mellitus observed over a period of 10 years or more. The authors^{1,2,3,4} have rendered a great service in this sustained comprehensive study in four distinct, yet closely correlated articles dealing with general observations, cardiac studies, ocular findings and peripheral vascular findings. This well ordered study, with the University of Pennsylvania, the George S. Cox Medical Research Institute and the Edward Robinette Foundation behind it, has the ring of authority and it brings together much valuable knowledge which should be in the hands of every physician.

It is surprising to note how little variation there is between this series of 100 patients, under strict management for 10 years or more and comparable non-diabetic groups. In other words, the diabetic with careful management, graduated doses of insulin and a relatively high carbohydrate and relatively low fat diet, with a few important exceptions, has his chance of survival and success in life, almost if not quite equal to the chance vouchsafed to those who are not so afflicted.

Russell Richardson, author of the leading

article dealing with general observations, gives this "Final Summary of Series of 4 Articles:

"1. In the 4 preceding papers, is presented a study of 100 patients with diabetes mellitus of 10 or more years' duration controlled by insulin and measured diets.

"2. Observations show that in at least 45 per cent of them the severity of the diabetes did not progress.

"3. Neither the duration nor the severity of the diabetes appears to influence the incidence of hypertension, infection, or ocular sclerosis. However, prolonged diabetes appears to increase the incidence of deep retinal hemorrhages and exudates and superficial hemorrhages in the eyes.

"4. The incidence of cardiac enlargement in those patients who had hypertension is about one-half that observed in non-diabetic hypertensives.

"5. In our patients under 50 years of age the incidence of cardiovascular disease was lower than that previously found in diabetics.

"6. Arteriosclerotic occlusive disease of the lower extremities was found in 46 per cent of the women examined and in 22 per cent of the men. This much higher incidence in diabetic women than in women without

diabetes parallels the greater frequency of coronary vessel disease in diabetic as compared with non-diabetic women."

1. Richardson, Russell and Bowie, Morris A.: Diabetes Mellitus as Observed in 100 Cases for 10 or More Years. General Observations. Amer. Jour. of the Med. Sciences. Vol. 209, No. 1, No. 874, page 1. January, 1945.

2. Edeiken, Joseph: Diabetes Mellitus as Observed in 100 Cases for 10 or More Years. Cardiac Studies. Amer. Jour. of the Med. Sciences. Vol. 209, No. 1, No. 874, page 8. January, 1945.

3. Leopold, Irving H.: Diabetes Mellitus as Observed in 100 Cases for 10 or More Years. Ocular Findings. Amer. Jour. of the Med. Sciences. Vol. 209, Vol. 1, No. 874, page 16. January, 1945.

4. Naide, Meyer: Diabetes Mellitus as Observed in 100 Cases for 10 or More Years. Peripheral Vascular Findings in 89 of These Cases. Amer. Jour. of the Med. Sciences. Vol. 209, No. 1, No. 874, page 23. January, 1945.

THE PHILOSOPHY OF PRACTICE

Like Oklahoma soil, the field of medicine must be carefully cultivated if an abundant harvest is to be expected. If the rows of a doctors life are choked with pig-weeds and cockle-burrs, it is because he has neglected the plow and the hoe. If the tares are permitted to take the field, professional talents are correspondingly dwarfed. At the outset, every doctor should plant and cultivate scientific accuracy, humane diplomacy, and the sacrificial love of his fellow man. Such industry will insure a full life with clean rows, a bountiful harvest and an honorable demise.

Menopause Symptoms • Senile Vaginitis • Pruritus Vulvae

*Effective
Ebb Relief with*

• Clinical reports agree that Schieffelin Benzestrol satisfactorily alleviates not only menopausal vasomotor reactions but also other associated climacteric symptoms, such as headaches, joint pains, nervousness and fatigability.

Dose: Oral 2 to 3 mg. daily.

Intramuscular $\frac{1}{2}$ to 1 cc. every 4 to 7 days.

• Schieffelin Benzestrol is used in relieving symptoms of senile vaginitis and associated pruritus vulvae by converting the atrophic epithelium to the adult functional type. For localized therapy in this condition Schieffelin Benzestrol is available as an ellipsoid tablet for vaginal insertion.

Dose: 1 or 2 vaginal tablets inserted daily.

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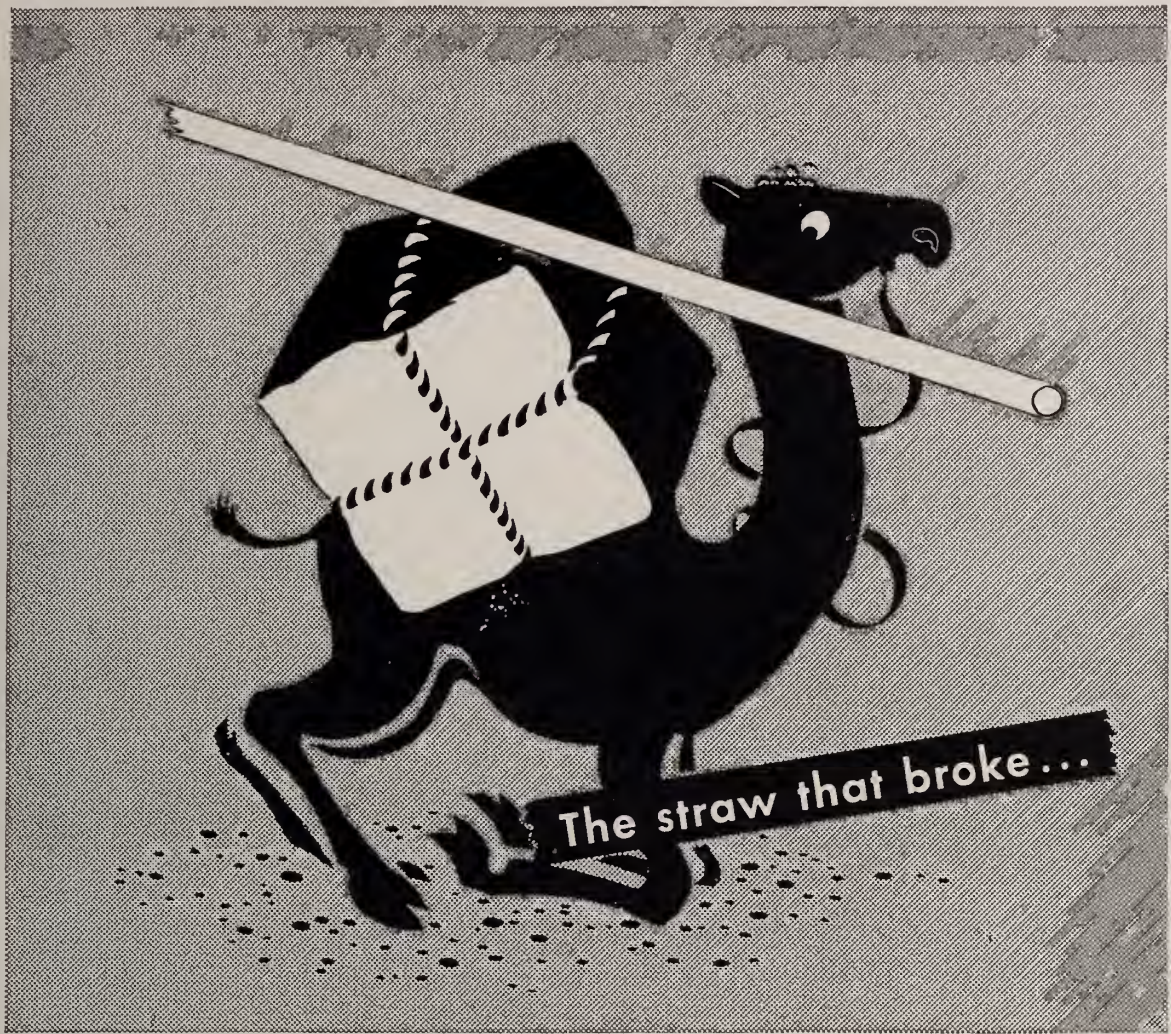
Literature and samples on request.



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When patients are subjected "to some physiologic strain, a febrile illness, hyperthyroidism, a period of unusual exertion, an attack of diarrhea, an operation, or perhaps mere curtailment of food intake, then nutritive failure is precipitated and evidences of ill health appear."¹

Vitamin reserves may be too meager to withstand increased metabolism or decreased ingestion. One way to spare patients the added debilitating effects of nutritive failure is to prescribe Upjohn vitamin preparations.

UPJOHN VITAMINS



Upjohn
KALAMAZOO 99, MICHIGAN

1. Bull. N. Y. Acad. Med. 18:497 (Aug.) 1942.

DO MORE THAN BEFORE — KEEP ON BUYING WAR BONDS

Governor Kerr Signs Health Bill



Governor Kerr signed the health bills in the presence of the members of the Legislature who had sponsored the program, the officials of the Oklahoma State Medical Association, the officials of the Oklahoma State Health Department. From left to right: Paul H. Fesler, Executive Secretary of the Oklahoma State Medical Association; Grady Mathews, M.D., Commissioner of Health; Senator Louis H. Ritzhaupt, Guthrie; Senator E. S. Collier, Taloga; Senator Bayless Irby, Boswell; Representative Creekmore Wallace, Oklahoma City; Representative E. R. Weaver, Stillwater; Tom Lowry, M.D., Dean of the University of Oklahoma Medical School; Representative R. M. Mountcastle, Muskogee; O. W. Starr, M.D., Drumright, Chairman of the Practice of Medicine Committee of the House; Senator Thomas Finney, Idabel; Senator M. O. Counts, Hartshorne, who sponsored the program in the House; Senator Homer Paul, Pauls Valley, President Pro-Tem of the Senate; Senator Pruitt; Representative Fletcher Johnson, Bristow; Senator J. C. Nance, Purcell. Representative Charles Flanagan, Walters; Representative William Parrish, Durant and Speaker E. W. Hines, Cordell were unable to be present.

The program provides for surveys and a hospital system and health centers. Appropriations of \$1,680,000.00 for a hospital, nurses' home, additions to the medical school at Oklahoma City, and a hospital at Ardmore were included in the program. One bill provided for a Board of Health to supervise the development of the program. The program authorizes the building of hospitals by one or more counties for the remote districts of the State.

All of the bills were finally passed and are now the law of Oklahoma. The Oklahoma State Medical Association appreciates the loyal support of their Representatives and are confident that they will support the development of the program in their respective districts. The legislation is only beginning—the development of the program will require time and will progress only as accepted by the local communities.

ATTENTION!

Attention of all physicians is called to the necessity of re-registering their license with the State Board of Medical Examiners by June 10. The annual re-registration fee is \$3, and checks should be made payable to the Oklahoma State Board of Medical Examiners.

Physicians who have been serving with the armed forces but who have returned to practice must re-register for 1945. Those still in service are exempt.

All communications should be addressed to J. D. Osborn, M.D., Secretary, Oklahoma State Board of Medical Examiners, Frederick, Oklahoma.

**POSTGRADUATE COURSE IN
SURGICAL DIAGNOSIS**

Early in June the postgraduate course in Surgical Diagnosis will be given at the following Centers: Guthrie, Stillwater-Cushing, Ponca City, Pawhuska and Bristow-Sapulpa.



Patrick Wu, M.D.

The Committee is very enthusiastic over our instructor Dr. Patrick Wu. Doctor Wu is a graduate of the University of Virginia, has had extensive training in New York, Chicago and several years at the Mayo Clinic, Rochester, Minnesota. In addition to his excellent training he has had many years of very active surgical practice.

Doctor Wu is an excellent speaker, has a magnetic personality and pleases every single person with whom he comes in contact as a scholar, a gentleman and a man of ability.

Gregory E. Stanbro, M.D.,
Chairman Postgraduate Committee.

HENRY H. TURNER LEAVES CLINIC

Dr. Henry H. Turner, Oklahoma City, has disposed of his interests in the Douglas Aircraft Workers' Clinic in Oklahoma City. He will devote his entire time to his private practice.

**DOCTOR, MEET THE
DARICRAFT BABY**

Perhaps you are "meeting" the Daricraft Baby every day in your own practice. If not, may we call to your attention the following significant points of interest about Vitamin D increased Daricraft:



1. Produced from inspected herds; 2. Clarified;
3. Homogenized; 4. Sterilized; 5. Specially Processed;
6. Easily Digested; 7. High in Food Value;
8. Improved Flavor; 9. Uniform; 10. Dependable Source of Supply.

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Official Proceedings of House of Delegates

Oklahoma State Medical Association--April 22, 1945, Oklahoma City

MINUTES OF THE FIRST SESSION

Sunday, April 22, 1945

The first session of the House of Delegates Meeting held April 22, 1945 at Oklahoma City, was called to order in the Crystal Room of the Skirvin Hotel at 9 a. m., by the Speaker of the House, Dr. George H. Garrison, Oklahoma City.

Following the call to order by the Speaker, the Chairman of the Credentials Committee, Dr. J. V. Athey, Bartlesville, stated that he and the members of his Committee had marked the Delegates present and that the records indicated a quorum was present.

The Speaker stated that it was suggested by the Council in the meeting of the night before, April 21, that the following motion as made by Dr. J. V. Athey, Bartlesville, be presented to the House of Delegates:

"Dr. Athey moved that a plea should be made to the House of Delegates at the meeting on Sunday, April 22, that every doctor who could possibly do so, to stay and go out to the Legislature on Monday morning, April 23, to see if he could do something to further the satisfactory passage of the Health Bill. Dr. Templin seconded the motion."

The Speaker then stated that the Constitution of the Association required two sessions of the House of Delegates at the Annual Meeting. He further stated that insofar as could be determined, no interval of time had been specified to lapse between the two sessions and it was his suggestion that the two sessions be held in the morning with a recess of a few minutes.

The reading of the minutes of the last meeting of the House of Delegates was called for and the minutes of the session held on October 22, 1944 were read by Mr. Paul Fesler, the Executive Secretary of the Association.

On motion by Dr. L. C. Kuykendall, seconded by Dr. C. E. Northcutt, the minutes were approved as read.

Following the adoption of the above motion, the Speaker, in compliance with the provisions of Chapter III, Section 4, Subsection (a), of the By-Laws, appointed the following Reference Committees: Resolutions Committee—Dr. F. W. Boadway, Ardmore, Chairman; Dr. J. L. Patterson, Duncan; Dr. Lewis J. Moorman, Oklahoma City. Tellers and Judges of Elections—Dr. C. E. White, Muskogee; Dr. Ned Burleson, Prague; Dr. F. P. Gastineau, Norman. Sergeant-at-Arms—Dr. W. S. Larrabee, Tulsa, and Dr. D. H. O'Donoghue, Oklahoma City.

At this time, the Speaker, in compliance with the provisions of Chapter VII, Section 3, of the By-Laws of the Association, called for the Annual Report of the Council.

Dr. C. R. Rountree, President, was recognized by the Speaker and read the following report.

Annual Report of Council—1944-1945

To the House of Delegates:

Meetings of the Council for the past year were held:

July 9, 1944
October 22, 1944
January 7, 1945
February 11, 1945

Reports from all Districts were published in the March Journal. Reports of the following Committees were also published:

Committee on Insurance—V. K. Allen, M.D., Chairman.

Committee on Library—Lea A. Riely, M.D., Chairman.

Committee on Maternity and Infancy—J. T. Bell, M.D., Chairman.

Medical Advisory Committee to the State Department of Public Welfare—Clinton Gallaher, M.D., Chairman.

Committee on Medical Economics—L. J. Starry, M.D., Chairman.

Medical Advisory Committee to the Vocational Rehabilitation Division of the State Board of Education—Clinton Gallaher, M.D., Chairman.

Committee on Public Health—John W. Shackelford, M.D., Chairman.

Committee on Scientific Work—J. H. Robinson, M.D., Chairman.

Committee on Necrology—H. A. Higgins, M.D., Chairman.

Committee on Study and Control of Tuberculosis—Floyd Moorman, M.D., Chairman.

Committee on Postgraduate Medical Teaching—Gregory E. Stanbro, M.D., Chairman.

Medical Advisory Committee to the Oklahoma Veterans' Assistance Program—John L. Day, M.D., Chairman.

Committee on Study and Control of Venereal Diseases—Alfred R. Sugg, M.D., Chairman.

Committee on Judicial and Professional Relations—E. H. Shuller, M.D., Chairman.

Advisory Committee to Woman's Auxiliary—E. Eugene Rice, M.D., Chairman.

Meetings were held by the following Committees:

Conservation of Vision and Hearing—E. Gordon Ferguson, M.D., Chairman.

Crippled Children—W. K. West, M.D., Chairman.

Industrial and Traumatic Surgery—J. S. Chalmers, M.D., Chairman.

Library—Lea A. Riely, M.D., Chairman.

Maternity and Infancy—J. T. Bell, M.D., Chairman.

Medical Advisory to Public Welfare—Clinton Gallaher, M.D., Chairman.

Medical Advisory to Vocational Rehabilitation Division—Clinton Gallaher, M.D., Chairman.

Necrology—H. A. Higgins, M.D., Chairman.

Postgraduate Medical Teachings—Gregory E. Stanbro, M.D., Chairman.

Post-War Planning—Tom Lowry, M.D., Chairman.

Public Health—John W. Shackelford, M.D., Chairman.

Study and Control of Cancer—Paul B. Champlin, M.D., Chairman.

Study and Control of Venereal Diseases—A. R. Sugg, M.D., Chairman.

Insurance—V. K. Allen, M.D., Chairman.

Medical Economics—L. J. Starry, M.D., Chairman.

Study and Control of Tuberculosis—Floyd Moorman, M.D., Chairman.

Finances

The detailed audit was published in the March Journal. The Association operated within the Budget as set up for the year. As instructed by the Council, \$2,000 additional series G bonds were purchased. The attached letter from the auditor is self explanatory (read letter).

In studying the membership dues, we find there was a loss of \$1,761.51 in 1944 as compared with the total for 1943. This loss is due to the fact that Members in Service who were in good standing paid dues of only \$4 for 1944 and no dues for 1945 and until the war is over. The income on the Journal shows an increase from its advertising of \$1,476.05.

Membership

The following is a comparison of membership statistics.

	1944	1945
Active Members	1,121	1,064
Service Members	298	308
Honorary Members	24	33
Associate Members	4	6
Total Membership	1,447	1,411

Members entering Armed Forces during the year	10
Service Members released during the year	19

Budget

The attached Budget was adopted at the January meeting (read Budget).

Miscellaneous

Attention is called to the change in the front cover of the Journal as approved at the last Annual Meeting in 1944.

The Executive Offices have been remodeled to include the New Council Room and Library. This was done at an expense of \$1,714.30 whereas the amount approved was \$1,850 excluding furniture. The offices are completed with the exception of an additional coat of paint and the venetian blinds which are necessary in order that the decorator fulfill his contract.

The Council approved a Booth at the Oklahoma State Fair, Oklahoma City, in September, 1944. This Booth was financed by \$175 from each of the following: The Publicity Committee of the Oklahoma State Medical Association; the Cancer Committee; the Oklahoma State Health Department and the Oklahoma Tuberculosis Association. This exhibit was very successful and many of the lay were reached who otherwise would not have been contacted. It was estimated that approximately 3,500 persons a day visited the Booth, the total for the week being 24,500. Reading material on the following subjects was distributed: Cancer; Tuberculosis; Socialized Medicine — pamphlets from National Physician's Committee and the Socialized Medicine Cartoon.

Revised abstract of the Prepaid Medical Plan was mailed to members. At a Special Meeting of the House of Delegates on October 22 the report of the Committee was accepted and steps taken to implement the Plan. A Board of Trustees consisting of the following members (9 doctors of medicine and 6 laymen) was selected by the Councilors:

Board of Trustees

Mr. Thomas Keltch, Alva
Mr. R. L. Kelsay, Hobart
Mr. R. L. Bosworth, Ponca City
Mr. Joe N. Hamilton, Oklahoma City
Mr. Glen Leslie, Shawnee
Mr. J. W. Westbrooks, Muskogee
John F. Burton, M.D., Okla. City
James Stevenson, M.D., Tulsa
A. S. Risser, M.D., Blackwell
O. C. Newman, M.D., Shattuck
T. H. McCarley, M.D., McAlester
J. B. Eskridge, Jr., M.D., Okla. City
H. C. Weber, M.D., Bartlesville
W. W. Cotton, M.D., Atoka
A. W. Pigford, M.D., Tulsa

Dr. John F. Burton and the Committee have been commended for their fine work in this connection.

In order to effect a closer relationship between the

Association and the Members, a tour was made of the State by the following, who presented the Legislative Program to each District and explained the various operations of the Association; Dr. C. R. Rountree, Dr. V. C. Tisdal, Dr. John Shackelford, Dr. W. Floyd Keller, Dr. John Burton, Dr. Tom Lowry and Mr. Paul Fesler.

Motion was made and carried that the Oklahoma State Medical Association proffer its services to the Governor and state agencies interested in the health and welfare of the people of the State if and when it could be of service to them in the professional capacity represented. This was accepted by the Governor. The Council feels that it is desirable for this Program to be explained to the House of Delegates.

The Council approved the following Legislative Program:

The Coroners Bill

The Board of Health Bill

The Basic Science Bill

The Medical School Appropriation

The Council also endorsed the Premarital Examination Bill.

The Executive Secretary will make a separate report to the House of Delegates relative to the Legislative Program. All of the Legislation is still pending and it is hoped that the Board of Health Bill will pass very much in line as presented by the Association. The Coroner and Basic Science Bills were not presented because they seemed to be controversial to the extent that they would interfere with the other Program and had no reasonable chance of passing. Some important Legislation was killed, including a Naturopath Bill.

The cooperation on the part of the medical profession was of great assistance and indicated the importance of active participation on the part of the medical profession relative to writing the medical and health laws of the State. We are told by the friends of medicine that the Association should be more active in furthering the health and welfare of the people of the State. Such activity will contribute more than anything else to obstruct practices which are not for the best interest of the people of Oklahoma. Whether we realize it or not, the care of the sick is largely controlled by local legislation. The Federal Government will not be able to inject undesirable regulations if the medical profession is able to control their local representatives. In practically every instance where the local doctor exerted his influence, his representative or senator has supported the Association's Program. This all points to the fact that it is most important that the Association should develop an adequate program of Public Relations.

The first Year Book of the Association, as suggested by Mr. Paul Fesler, Executive Secretary, was published and distributed to the membership. This book was paid for by advertising and was published through no expense to the Association. It has been very well received and

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several expressions of approval have reached the Executive Offices. It seems to have filled a long felt need to the members. Special attention is called to the complete Roster of Physicians licensed to practice medicine in the State of Oklahoma. So far as we know, it is the first list to be published and is as complete and accurate as it is possible to make it.

The State Department of Rehabilitation requested that an advisory committee of physicians be appointed. The following committee was approved and appointed and has met regularly:

Clinton Gallaher, M.D., Shawnee, Chairman
Bert F. Keltz, M.D., Okla. City
James O. Asher, M.D., Clinton
John C. Perry, M.D., Tulsa
Emmis M. Gullatt, M.D., Ada
Fred O. Pitney, D.D.S., Okla. City
Mr. Bert Loy, Oklahoma City

At the request of the Honorable Milt Phillips of the Veteran's Assistance Program, the President appointed the following Committee to serve in an advisory capacity with regard to psychiatric problems.

John L. Day, M.D., Chairman
Felix M. Adams, M.D., Vinita
D. W. Griffin, M.D., Norman
C. E. Leonard, M.D., Okla. City
Coyne H. Campbell, M.D., Okla. City
Major Moorman Prosser, M.D., Muskogee

The Annual Meeting scheduled in Oklahoma City April 23-25 was ordered canceled by the Office of Defense Transportation. Prior to the cancellation, the Scientific Work Committee had gone far toward the completion of the program which promised to be one of the best in the history of the Association. Excellent cooperation had been received from the several Scientific Sections. All exhibit space had been sold. All money has been refunded to exhibitors upon notice of cancellation of the meeting.

It is deeply regretted that circumstances incident to the War prevent a regular and complete meeting of the Association this year. It is the desire of the Council and present Officers to assist the incoming Officers and Councilors of their full support in furthering the program of the Association for the ensuing year.

H. E. COLE COMPANY

Public Accountant

Plaza Court

Oklahoma City 3, Oklahoma

March 30, 1945

Oklahoma State Medical Association,
210 Plaza Court,
Oklahoma City, Oklahoma
Gentlemen:

This letter is supplemental to our Audit Report of February 22d, 1945, and is to advise you that all books and records were thoroughly checked and everything found in order.

The Bonds of the Association, which are kept in a safety deposit box of the Liberty National Bank, were also checked as of February 21, 1945, and are listed as follows:

	Issue Price	Maturity Value
SERIES F		
No. C19813F	\$ 74.00	\$ 100.00
No. C19814F	74.00	100.00
No. C19815F	74.00	100.00
No. C19816F	74.00	100.00
No. M26725F	740.00	1,000.00
No. C81811F	74.00	100.00
No. D35392F	370.00	500.00
No. M90162F	740.00	1,000.00
SERIES G		
No. M1194620G	1,000.00	1,000.00
No. M1898236G	1,000.00	1,000.00
No. M3473265G*	1,000.00	1,000.00
No. M3473266G*	1,000.00	1,000.00

U. S. TREASURY BONDS—2¼ %

No. 10963C	1,000.00	1,000.00
No. 10964D	1,000.00	1,000.00
No. 10965E	1,000.00	1,000.00
No. 10966F	1,000.00	1,000.00
No. 10967H	1,000.00	1,000.00
No. 10968J	1,000.00	1,000.00

(*Purchased in 1945.)

These bonds are all issued in the name of OKLAHOMA STATE MEDICAL ASSOCIATION.

Very truly yours,

(Signed) H. E. COLE COMPANY

On motion by Dr. McLain Rogers, seconded by Dr. O. E. Templin the Annual Council Report was approved as read.

The Speaker then announced that Reports from all 10 Councilor Districts had been published in the March Journal and asked the pleasure of the House as to the disposal of this part of the agenda.

It was moved by Dr. O. E. Templin, seconded by Dr. C. E. White that the reports be approved as announced by the Speaker. The motion carried.

The next order of business was the Report of the Standing Committees. Dr. Garrison announced that the Reports of the Scientific Work Committee and the Judicial and Professional Relations Committee had been reported in the March Journal and that the report of the Medical Education and Hospitals was on hand, in order and required no action by the House. He also announced that the Annual Session Committee had no report to make and that the report of the Publicity Committee would not be made at this time. The pleasure of the House was asked in regard to the disposal of the reports as announced by the Speaker.

It was moved by Dr. C. S. Chambers, seconded by Dr. C. E. White that the reports be approved as announced by the Speaker. The motion carried.

The following report was announced by the Speaker on hand:

Report of Committee on Medical Education and Hospitals

The Committee on Medical Education and Hospitals submits the following report:

The Committee on Medical Education and Hospitals realizes that these are critical times for medical education and organized hospitals. The War has precipitated a very acute shortage of nurses, which has been so pressing that House Bill 1284, introduced by Representative May of Kentucky, proposed to insure adequate medical care for the armed forces by providing for the registration, selection and induction of nurses.

The accelerated program of medical education is serving its purpose in supplying more doctors for the emergency. Just how well these doctors are being prepared in comparison with those in normal times is still a question. But with the reduced length of time, the medical

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courses, the internships, and the few residencies services, we cannot expect the high standards to be maintained, as before the war.

There is now and will be after the war, a marked shortage of doctors. It is estimated that between twenty and thirty thousand doctors will remain in the armed forces or veteran facilities. We must evaluate this situation by remembering that the Federal Government will offer medical services for veterans and their families, and the large number of government hospitals which have been established during the war period.

The council on medical education and hospitals of the American Medical Association, has repeatedly urged the necessity for changes in the present policies of governmental agency, having to do with the education of pre-medical students. The House of Delegates of the American Medical Association, at its meeting in Chicago in June, 1944, addressed a communication to the President, the Army and Navy Departments, and to the Selective Service system, urging that immediate steps be taken to remedy this situation.

Attention is called to House Bill 634, which includes provisions for the deferment of an adequate number of pre-medical students for a period of two years, and further provides for the deferment of such numbers of such members of medical students as will be sufficient to supplement civilian sources of students for the maintenance of full classes. The bill also calls for the return to the medical and pre-medical studies, all qualified members for the armed forces who have honorably served a year in military service. We heartily approve of this bill, and also recommend the increased facilities of the University of Oklahoma School of Medicine to demand and train more doctors and nurses.

Senate House Bill 191, known as the Hill Burton Hospital Construction Bill, proposes an appropriation of \$110,000,000 to aid States in surveying their hospital and public health centers, and in planning and constructing additional facilities. The Board of Trustees of the American Medical Association has expressed the opinion that the bill should receive the support of the medical profession. We endorse the general principles of this bill as a logical approach to the solution of the question of adequate hospital care for the people of our nation and our State. We had, however, rather see the State Legislature solve its own problems where the State of Oklahoma is concerned. We endorse the hospital bills which were introduced at the present session of the Oklahoma State Legislature.

We commend the Oklahoma State Board of Medical Examiners for upholding the high standards of medical practice in the State of Oklahoma. We commend Governor Kerr in the present administration of the State of Oklahoma for hearty support in upholding the standards of medical education and improving the health facilities for the people of Oklahoma.

Respectfully submitted,

John M. Carson, M.D.

Tom Lowry, M.D.

Sam McKeel, M.D.

Dr. V. C. Tisdal, Chairman of the Public Policy Committee was called on to present his report. He asked that the report be given by Mr. Paul Fesler, Executive Secretary of the Medical Association.

Mr. Fesler talked on the following Legislative measures and stated:

1. A Naturopath Bill was presented to the Legislature but through the efforts of the Association, was killed in committee.
2. The Board of Health Bill passed the House with amendments providing for an osteopath and chiropractor. The representatives of these cults were removed in the Senate Committee and the Bill passed the Senate as recommended by the Committee. The Bill is now pending before the House of Representatives. Mr. Fesler requested the Councilors and Delegates to remain over Monday, April 23, and contact their Legislators, urging them to sup-

port the Bill as amended by the Senate. (Note: The Bill finally passed as amended by the Senate.)

3. House Bill 463 amending the present University Hospital laws to make it possible for only doctors of medicine to serve on the faculty and staff has been passed.
4. House Bill No. 468 providing for a model hospital inspection law was passed.
5. House Bill 476 providing for a survey of medical and hospital facilities was passed.
6. House Bill 477, a Bill providing for the Health Commissioner to match funds with counties to set up health centers was passed.
7. House Bill 478 providing for the Commissioner of Health to set up a statewide system of hospitals was passed with amendments in the Senate eliminating appropriations to match funds for public hospitals. This Bill was adopted by the House of Representatives as amended.
8. Mr. Fesler announced that appropriations providing for \$1,680,000.00 were pending in Conference Committee for the purpose of construction of buildings at the University of Oklahoma Medical School and Hospital. \$250,000.00 of which was to be used for the construction of buildings at the Southern Oklahoma Hospital at Ardmore when the local county had raised funds to match the appropriations.
9. Another Bill was passed providing for the Southern Oklahoma Hospital to be placed under the supervision of the University of Oklahoma Board of Regents.

Mr. Fesler was then requested to explain the Co-ordinated Hospital Service Plan. Copies of the Pepper Committee Report, the Federal Hospital Construction Program, and the Co-ordinated Hospital Service Plan Map, were distributed to the members of the House. Mr. Fesler then explained the Plan in detail, by the use of lantern slides.

Dr. C. R. Rountree was then recognized by the Speaker and said, "The Council has approved the Plan that has just been explained to you. I know there must be some questions that you have to ask about the matter. I do not think it should go on record unless the House approved of it. I would like to hear some discussion."

Lengthy discussion followed this statement.

It was moved by W. S. Larrabee, Tulsa, seconded by Dr. D. H. O'Donoghue, that the Plan regarding the enabling legislature be approved and accepted. The motion carried.

The next order of business was the Reports of the Special Committees. Dr. Garrison announced that the reports of the following Committees had been published in the March Journal and asked the pleasure of the House as to disposal. Insurance Committee; Library Committee; Maternity and Infancy Committee; Medical Advisory to the Public Welfare Department; Medical Advisory to Vocational Rehabilitation Division; Medical Economics; Public Health Committee; Study and Control of Tuberculosis; Study and Control of Venereal Diseases; Advisory Committee to Woman's Auxiliary; Medical Advisory Committee to the Oklahoma Veteran's Assistance Program.

On motion by Dr. D. H. O'Donoghue, seconded by Dr. John Burton, the reports of the Committees as read by the Speaker were approved.

The Speaker then stated that the Postgraduate Medical Education Committee had asked for time to present a supplementary report in addition to the one published in the March Journal. Dr. Gregory E. Stanbro, Chairman, was recognized.

Supplementary Report of Postgraduate Committee

The Postgraduate Committee employed an instructor to start instruction in Surgical Diagnosis February 1, 1944, and on September 15, 1944, after giving him a complete trial and after the completion of three circuits we concluded that his work as an instructor was not satisfactory and we discontinued the course.

Gentlemen, you realize that it is difficult to secure the services of any surgeon who is competent and has had

Penicillin

DOSAGE TABLE*

INDICATIONS	INITIAL DOSE (UNITS)	CONTINUING DOSAGE (UNITS)	UNITS IN 24 HR.	REMARKS
Serious Infections (staphylococcus, clostridium, hemolytic streptococcus, anaerobic streptococcus, pneumococcus, gonococcus, anthrax, meningococcus) Adults and children	15,000 to 20,000	(a) Intravenous drip: 2000 to 5000 every hr.	40,000 to 120,000 or more	(a) Dissolve ½ of 24 hr. dose in 1 liter (1000 cc.) normal saline; let drip at 30 to 40 drops per minute.
		or (b) Intramuscularly: 10,000 to 20,000 every 3 or 4 hr.	40,000 to 120,000 or more	(b) Concentration: 5000 U. per cc. normal saline.
		or (c) Intramuscular drip	40,000 to 120,000 or more	(c) Total daily dose in 250 cc. normal saline.
Infants	5000 to 10,000	3000 to 10,000 intramuscularly every 3 hr.	20,000 to 40,000 or more	Each dose in 1 or 2 cc. of normal saline.
Chronically infected compound injuries, osteomyelitis, etc. Adults and children	5000 to 10,000	10,000 every 2 hr. or 20,000 every 4 hr. intramuscularly or intravenously. Larger doses may be necessary at times.	40,000 to 120,000 or more	Concentration for intramuscular inj.: 5000 U. per cc. normal saline. For intravenous inj.: 1000 to 5000 U. per cc. Supplement with local treatment.
Sulfonamide Resistant Gonorrhea	20,000 every 3 hr. intramuscularly for 5 doses		100,000	Results of treatment should be controlled by culture of exudate.
Empyema Adults and children	30,000 to 40,000 once or twice daily into empyema cavity		30,000 to 80,000	Dissolve in 20 to 40 cc. normal saline and inject into empyema cavity after aspiration of pus.
Meningitis Adults and children	10,000 once or twice daily into subarachnoid space or intracisternally		10,000 to 20,000	Concentration: 1000 U. per cc. normal saline.
Bacterial Endocarditis Adults and children	25,000 to 40,000	25,000 to 40,000 every 3 hr. intramuscularly	200,000 to 300,000	Continuous treatment for 3 weeks or longer. In a few cases the intravenous drip is more advantageous.

*Based upon recommendations by Chester S. Keefer, War Production Board Penicillin Leaflet, Apr. 1, 1945; and by Wallace E. Herrell and Roger L. J. Kennedy, *Journal of Pediatrics*, 25:505, Dec., 1944.

● Write for pocket size copies of this Dosage Table

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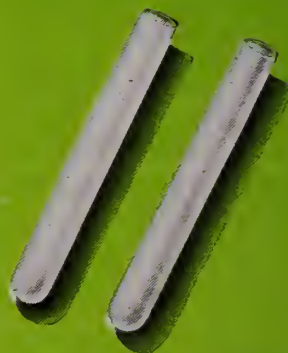
depends

not on disappearance of
spirochetes alone



nor merely

the reversal of positive
Wassermann reaction



but on

whether the treatment is such that within
the shortest possible time the patient
receives maximum protection against
relapse and the infection of others.



PEOPLE who feel well balk at the idea of taking weekly injections, particularly if the injections are painful or make them feel ill. Therefore, once the early signs of syphilis disappear, many patients become indifferent to treatment. A recent survey shows that:

only 1 out of 4 clinic patients with early syphilis, undergoing the standard 70-week course, continues treatment long enough to receive minimal protection against infectious relapse.

A realistic approach to the problem is provided by the use of Mapharsen, a rapidly administered arsenical that minimizes the discomfort of injections; one which is well tolerated by the patient; and one which gives a high degree of protection in a short period of time. Consideration of these factors increases the possibility of securing sufficient cooperation on the part of the patient to insure the continuance of therapy beyond the point where relapse or the infection of others is possible.



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experience for this type of work, who is willing to give up his practice for a period of two years. During these war times it has been doubly difficult. We have absolutely combed the country.

Until last week it would have been necessary for me to report to you that we did not have an instructor, but I am pleased to state that we now have a competent instructor.

First, I would like to make one comment on our Committee. To have a Committee made up of six men from different sections of the state, who have come to Oklahoma City for Committee meetings six times during the past year, is to be highly commended.

At the State meeting of the County Secretaries in February, I brought the name of Dr. Patrick Wu and his qualifications before them. I asked them at that time to consult their Societies and seek their approval of Doctor Wu. Most of the Secretaries sent in their approvals.

Dr. Patrick Wu is 39 years old, received his M. D. degree in 1928 at the University of Virginia, M. S. degree in 1932 at the University of Minnesota and in 1933 received his Ph. D. degree at the University of Minnesota. He served two years internship at the University of Virginia Hospital, Charlottesville, Virginia. From 1935 to 1938 he was a resident surgeon in the Peiping Union Medical College Hospital in China. He has had postgraduate work at the Mayo Clinic, the Columbia Medical Center and the University of Chicago. He belongs to the Phi Rho Sigma, Sigma Xi, American College of Surgeons, Society for Experimental Biology and Medicine, and the Chinese Physiological Society. His experience has been extensive. He was attending Surgeon at the Lester Chinese Hospital and Fellow in Experimental Surgery and Clinical Research in Shanghai, during 1933 and 1934; Assistant in Surgery at the Peiping Union Medical College from 1935 to 1938; Assistant Professor of Surgery at Peiping Union Medical College from 1939 to 1941; and from July 1, 1941 to the present has been Fellow in Surgery at the Mayo Clinic.

At our request, Doctor Wu came to Oklahoma City March 11, 1945, and our Committee met with him. The following Monday he talked to the students at the Medical School, and visited St. Anthony Hospital. Our entire Committee was very enthusiastic about him. At that time he told us he would advise us within six weeks after he left here, as to whether or not he would accept the instructorship. This week we received a letter from him stating that he had decided to accept this position.

Doctor Wu is highly recommended by The Commonwealth Fund. Doctor Evans and Mr. Smith, both of The Commonwealth Fund, interviewed Doctor Wu while he was in New York, after leaving here, and both are favorably impressed with him and were of the opinion that the Committee would be very fortunate to secure his services. References from Doctor Balfour of the Mayo Clinic are very praiseworthy. Dr. Grady Mathews, Commissioner, Oklahoma State Health Department, is in favor of employing Doctor Wu. We who have seen Doctor Wu and know him are very enthusiastic.

On completion of this course in Surgical Diagnosis Doctor Wu will return to Hongkong, China, where he will again practice and teach general surgery.

In conclusion, your Postgraduate Committee is very glad to report that we have engaged Dr. Patrick Wu to teach our postgraduate course in Surgical Diagnosis. Doctor Wu is unusually well grounded, comes highly recommended from every source, has a pleasing personality, is enthusiastic and a magnetic speaker.

We are planning on resuming the course in Surgical Diagnosis on or about June 1. I urge you to return to your respective County Societies and report the foregoing to them that every provision may be made for a successful course in Surgical Diagnosis in your community.

A motion was made by Dr. A. S. Risser and seconded by Dr. O. E. Templin that the report given by Dr. Stanbro be approved and accepted. Motion carried.

The Speaker then stated that the following report was

on hand, in order and required no action from the House.

Report of Crippled Children's Committee

The Crippled Children's Committee submits the following report to the House of Delegates.

In spite of the shortage of manpower the work of caring for the crippled child has gone on very satisfactorily. After many years of corrective work and educational instruction by the staff at the Crippled Children's Hospital, we have about caught up in the care of the so-called neglected crippled child. The Crippled Children's clinics held over the state during the past 18 years have resulted in much effective educational instruction both to the parents and to the county officers, who are interested in this phase of social welfare. We will continue to have probably the same percentage of congenital deformities and anomalies but the work will be lessened because people have learned to follow the advice of their family physician and thereby bring the child to the crippled children's clinics much earlier.

During the infantile paralysis epidemic, a great majority of the cases were treated immediately at the Crippled Children's Hospital, the Western Oklahoma Hospital and the hospitals in Tulsa, Oklahoma. As a result of this early treatment, we will not have the large percentage of neglected poliomyelitis cases resulting in severe deformities that have been our experience in the past.

The National Foundation for Infantile Paralysis is now large enough that additional funds are available at a moment's notice in case of any future poliomyelitis epidemic. The Foundation is also interested in the founding of a physical therapy school for the education of qualified teachers. In case the University Hospital can find the proper personnel for this work such a school will probably be functioning within the next year or so.

One of the greatest problems in the treatment of crippled children is osteomyelitis, acute and chronic. With only a brief period to study the results it is too early to say that the use of penicillin will be revolutionary in the treatment of this dread bone infection. The hospital records show that acute osteomyelitis admitted to the clinic, within 48 hours, shows a very definite improvement in the clinical course of the disease. Surgery has been unnecessary in a large percentage of these cases. In the chronic cases of osteomyelitis, by using penicillin before and after surgery, systemically and locally it has been possible to close the wounds except for a small catheter, through which the local penicillin is introduced, thereby reducing the hospital stay and shortening the period of convalescence.

At the Crippled Children's Hospital the two most serious fractures are fractures of the elbow and the shaft of the femur. Fracture of the elbow frequently necessitates open reduction under the most favorable surroundings. Fracture of the femur should be hospitalized and treated by skeletal wire traction. The commoner and less grave type of fractures are treated adequately in the out-patient clinics.

For additional improvement in the care of the crippled child an adequate isolation building should be built. At the present time active surgical treatment is interrupted when a contagious disease breaks out in the orthopedic ward. The University Hospital administration is making every effort to improve this situation.

The Crippled Children's Commission of the State of Oklahoma has been functioning very efficiently. Cooperation between the medical fraternity, the field nurses and the social service departments as well as the administration of the Commission has all been to the advantage of the Crippled Child.

W. K. West, M.D., Chairman

W. Pat Fite, M.D.

C. A. Traverse, M.D.

The Speaker stated that reports would be published at a later date by the following committees: Conservation of Vision and Hearing; Industrial and Traumatic Surgery; Military Affairs; and Post War Planning.

Dr. Garrison then read the Necrology Report as published in the March Journal and added the following names:

R. D. Watson	Oklahoma City	March 14, 1945
Paul W. Friedman	Stillwater	March 14, 1945
Ralph E. Myers	Oklahoma City	March 14, 1945
A. W. Roth	Tulsa	March 19, 1945
J. B. Lampton	Sapulpa	March 28, 1945
Austin Hutchinson	Bixby	March 28, 1945

After the list had been read, the Speaker asked that the House stand for a moment in silence.

Motion was made by Dr. John Haynie, *seconded* by Dr. J. S. Fulton, that the report be accepted. *Motion carried.*

Dr. Paul Champlin, Enid, was next recognized by the Speaker to present his report on the Cancer Committee.

Report of Committee on Study and Control of Cancer

Your Committee on the Study and Control of Cancer has been fairly active during the past year. A booth was sponsored at the State Fair in cooperation with the State Tuberculosis Society and the State Health Department. A large amount of literature was given out and several thousand people visited this booth. In cooperation with Doctor E. S. Lain and through some anonymous donor, 1,000 copies of a booklet entitled, "Cancer—A Study for Laymen" were purchased. This booklet was to be sent free of charge to all public libraries (city, college and high school) in the state so that authentic information in regard to cancer would be available to all people who wished to look it up.

The American Society for the Control of Cancer has been reorganized and renamed "The American Cancer Society." In the reorganization laymen have been given the majority on the Board of Directors. In the past, the activities of the society have been principally that of lay education which has been accomplished through the women's organization known as the "Women's Field Army." Your Committee has worked actively with this organization.

The plan for the future is to raise funds through lay organizations with the formation of branch societies throughout the state, counties and cities. These branches are to be permanent committees lasting from year to year with the purpose of conducting annual drives for funds. The funds so raised are to be divided equally between the state and the parent organization. This money is to be spent both locally and nationally for a greatly increased program of research, education and service, in the formation and support of organized tumor clinics and aid to the incurable.

The American Cancer Society has appointed Eric A. Johnston, President of the United States Chamber of Commerce, as Chairman of the drive. He, in turn, has appointed L. C. Griffith, head of the Griffith Theatres of Oklahoma, as State Chairman. Mr. Griffith through his organization has appointed temporary chairmen for each county and city in the State. They have already formed permanent organizations in many counties and cities in the State.

The quota for the State of Oklahoma is \$150,000.00, which should be raised without difficulty. That means that approximately \$75,000.00 will be at the disposal of the Oklahoma Chapter of the American Cancer Society which, (working in active cooperation with your Cancer Committee, will enable us to carry out many worthwhile projects.

Your Committee feels that this is one of the biggest steps forward that has ever been made in regard to cancer for many years. We feel that this drive should be actively encouraged by every doctor in the State.

Respectfully submitted,

Paul B. Champlin, M.D., Chairman

Joseph W. Kelso, M.D.

W. Floyd Keller, M.D.

Ralph A. McGill, M.D.

I. A. Nelson, M.D.

A motion was made by Dr. Clinton Gallaher, *seconded* by Dr. O. E. Templin that the Cancer Com-



UNTIL her physician has opportunity to observe and treat her symptoms, many a woman—even today—faces the failing fires of the menopause in confusion.

Baffled by irregularity and fits of depression, harried by pain and vasomotor disturbances, she often fears the interruption of a productive life. But when she seeks your advice, you can take satisfaction in the knowledge that you have the answer to her problem—*estrogenic therapy*.

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With this product, you may rekindle many of those fitful fires . . .

SOLUTION OF

*Estrogenic
Substances*

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mittee Report be approved and accepted. Motion *carried*.

Since there were no amendments to the Constitution and By-Laws, this order of business was passed by the Speaker.

The next order of business was the invitation for the next Annual Meeting and the Speaker recognized Dr. L. Chester McHenry, Oklahoma City.

Dr. McHenry said, "Since the Annual Meeting for 1945 has been canceled by the Office of Defense Transportation, Oklahoma City would like the privilege of extending the invitation to hold the Annual Meeting for 1946, if permitted, in Oklahoma City."

A motion was made by Dr. O. E. Templin, *seconded* by Dr. L. R. Kirby, that the invitation be accepted. Motion *carried*.

The Speaker next asked for a motion concerning the dues of the Association for 1946.

Dr. Finis Ewing made the motion that the dues be continued at \$12.00 per year. The motion was *seconded* by Dr. F. W. Boadway and *carried*.

The Resolutions Committee was then asked for the introduction of the resolutions. Dr. F. W. Boadway, Chairman, presented the following three resolutions which were presented by the Speaker.

Resolution Postgraduate Education

The House of Delegates of the April, 1945 Session of the Oklahoma State Medical Association desires to express appreciation and thanks to the Oklahoma State Health Department and the United States Public Health Service, Washington, D. C., for their financial support in making possible the postgraduate programs in internal medicine and surgical diagnosis in the State of Oklahoma.

It is the opinion of the House of Delegates from numerous letters, comments and resolutions from County Medical Societies, that hundreds of physicians in our medical profession have benefitted by reason of the postgraduate programs in Oklahoma.

Further, we request that a copy of this resolution be sent to Dr. Grady F. Mathews, Commissioner, Oklahoma State Health Department, whose valued assistance to the profession in Oklahoma has been noted, also a copy be sent to the United States Public Health Service, Washington, D. C.

Resolution Governor Robert S. Kerr

WHEREAS, The Honorable Robert S. Kerr, Governor of Oklahoma, has during the past year demonstrated a broad understanding of the problems of medicine, public health and general welfare of the people.

AND WHEREAS, he has actively supported desirable legislation having to do with medicine, public health and medical education in the State of Oklahoma.

THEREFORE, BE IT RESOLVED, that the House of Delegates of the Oklahoma State Medical Association in behalf of the people of the State should record its sincere appreciation of the services thus rendered,

BE IT FURTHER RESOLVED, that the House of Delegates of the Oklahoma State Medical Association does hereby commend and express its appreciation for the continuance in office of Grady F. Mathews, M.D., as Commissioner of Health of the State of Oklahoma. The medical profession has the utmost confidence in this man as an administrator of the public health activities of our State.

BE IT FURTHER RESOLVED, that the heartiest co-operation of the Association is extended to Governor Kerr with respect to all matters pertaining to the health of the people of Oklahoma.

Resolution The Commonwealth Fund

The House of Delegates at the April Session of the Oklahoma State Medical Association desires to go on record and express appreciation to The Commonwealth Fund of New York for their liberal financial support in

making possible the post-graduate instruction in obstetrics, pediatrics, internal medicine and surgical diagnosis in the State of Oklahoma.

From resolutions of County Medical Societies, comments of individuals and the obvious enthusiasm in the course in surgical diagnosis now under way, it is apparent that hundreds of physicians throughout the state are appreciative of and have benefitted by reason of these courses.

We request that a copy of this resolution be sent to The Commonwealth Fund of New York.

The Speaker then presented the names on the desk that had been presented, in order and through the proper channels for Honorary Membership:

Ralph V. Smith, Pryor
Floyd E. Watterfield, Muskogee
P. L. McClure, Fort Cobb

On motion by Dr. L. Chester McHenry, *seconded* by Dr. J. V. Athey, these were elected to Honorary Membership.

The Speaker then presented the name on the desk that had been presented in order and through the proper channels for Affiliate Membership in the American Medical Association.

W. H. Livermore, Chickasha

On motion by McLain Rogers, *seconded* by W. G. Husband, Hollis, Dr. Livermore was approved for Affiliate Membership in the American Medical Association.

A motion was made by Dr. James Stevensen, *seconded* by Dr. O. E. Templin that a 5-minute recess be declared, the meeting to reconvene for further consideration of business. The motion *carried*.

MINUTES OF THE SECOND SESSION April 22, 1945, Okla. City

The second and final session of the House of Delegates was called to order by the Speaker, Dr. George H. Garrison, at 11:45 A. M., Sunday, April 22, 1945, in the Crystal Room of the Skirvin Hotel, Oklahoma City.

Following the call to order, the Credentials Committee announced a quorum present, and upon declaration of the Speaker, the report was *adopted*.

The Speaker called for consideration of any unfinished business of the preceding session. Since there was no unfinished business, this part of the agenda was passed.

At this time the Speaker stated that the House had heard the Resolutions as presented by the Resolutions Committee and asked the pleasure of the House.

A motion was made by Dr. McLain Rogers, *seconded* by Dr. H. K. Speed that the Resolutions be accepted as presented. The motion *carried*.

It was so ordered by the Speaker and stated in the Resolutions that copies of the Resolutions be sent to Governor Robert S. Kerr, Dr. Grady F. Mathews, United States Public Health Service, and The Commonwealth Fund.

The Speaker called for miscellaneous and new business. There was none.

After stating that there were no amendments to the By-Laws to be considered, the Speaker called for the Election of Officers, and asked for nominations for President.

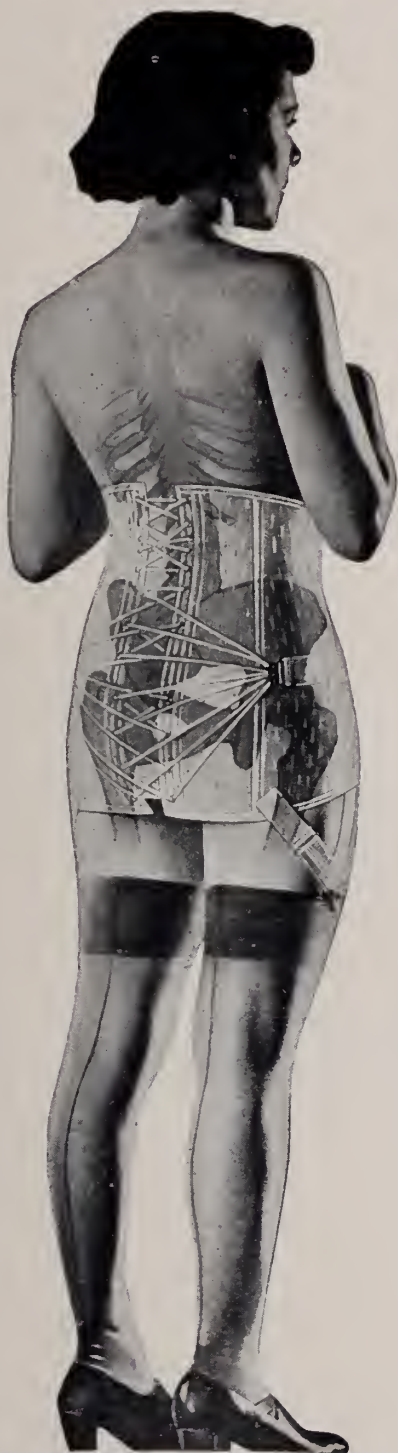
The Speaker announced that the first election would be that of President-Elect and recognized T. H. McCauley, McAlester who made the following remarks: "It is a pleasure to obey the mandates of the Pittsburg County Medical Society for this high office. When we look around for a man for this job, we think of his integrity. This man's is unquestionable. We think of his experience, capability and faithfulness to his patients. In this case, his is the best of any. We want a man who has always adhered to the best practice of medicine, and his service to organized medicine. In this, too, this man scores high.

"It is customary to mention a man's military, political and religious record. Regarding this man's military record, he is a veteran of world War No. 1. Regarding his

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politics—he was born in Texas! Regarding his religion, this man practically paid off the mortgage on the First Baptist Church in McAlester.

"It gives me great pleasure to present the name of L. C. Kuyrkendall for President-Elect."

Additional comments regarding Dr. Kuyrkendall were made by Drs. Finis Ewing, J. S. Fulton and John Haynie.

A *motion* was made by Dr. O. E. Templin that the nominations cease and that Dr. Kuyrkendall be elected by acclamation. The motion was *seconded* by Dr. Tom Lowry and *carried*.

Dr. Kuyrkendall was called upon for a speech and said, "Gentlemen, I am overcome."

Following the election of President-Elect, nominations were in order for Vice-President. Dr. W. S. Larrabee, Tulsa, was recognized by the Speaker and nominated Dr. Ralph McGill of Tulsa for the office of Vice-President.

A *motion* was made by Dr. Tom Lowry, *seconded* by Dr. O. E. Templin that the nominations cease and Dr. McGill be elected by acclamation. The motion *carried*.

The Speaker then called for nominations for Secretary-Treasurer, and recognized Dr. Finis Ewing who presented the name of Dr. Lewis J. Moorman, Oklahoma City.

A *motion* was made by Dr. R. Q. Goodwin, *seconded* by Dr. O. E. Templin, that the nominations cease and Dr. Moorman be elected by acclamation. The motion *carried*.

The Speaker then called for nominations for Delegate to the American Medical Association and recognized Dr. F. W. Boadway who presented the name of Dr. C. R. Rountree. Dr. O. C. Newman *seconded* the presentation of Dr. Rountree's name.

A *motion* was made by Dr. L. R. Kirby that the nominations cease and that Dr. Rountree be elected by acclamation. The motion was *seconded* by Dr. Carroll Pounders and *carried*.

The Speaker then called for nominations for Alternate Delegate to the American Medical Association, and recognized Dr. McLain Rogers who presented the name of Dr. J. D. Osborn, Frederick.

A *motion* was made by Dr. Finis Ewing, *seconded* by Dr. R. Q. Goodwin, that the nominations cease and Dr. Osborn be elected by acclamation. The motion *carried*.

The Speaker then called for nominations for Councilor of District No. 2 and recognized Dr. J. L. Bonham who presented the name of Dr. J. Wm. Finch for re-election.

A *motion* was made by Dr. L. Chester McHenry, *seconded* by Dr. Gregory E. Stanbro, that the nominations cease and Dr. Finch be elected by acclamation. The motion *carried*.

The Speaker called for nominations for Councilor of District No. 5 and recognized Dr. F. W. Boadway who presented the name of Dr. J. L. Patterson for re-election. Dr. P. H. Anderson *seconded* the presentation of Dr. Patterson's name.

A *motion* was made by Dr. Floyd Keller, *seconded* by Dr. R. Q. Goodwin, that the nominations cease and Dr. Patterson be elected by acclamation. The motion *carried*.

The Speaker called for nominations for Councilor for District No. 8 and recognized Dr. Finis Ewing, Muskogee, who stated that at a caucus of the District preceding the streamlined House of Delegates Meeting, it was unanimously decided that the name of J. G. Edwards, Okmulgee be presented for nomination.

A *motion* was made by Dr. J. L. Morrow, *seconded* by Dr. O. E. Templin that the nominations cease and Dr. Edwards be elected by acclamation. The motion *carried*.

Dr. F. P. Baker, Tahleah, asked for the floor and was recognized by the Speaker. Dr. Baker stated that since Councilor L. C. Kuyrkendall had been elected President-Elect, the need of a nomination for Councilor of District No. 9 existed.

The Speaker then called for nominations for Councilor

of District No. 9. Dr. Baker was again recognized and presented the name of Dr. Earl Woodson, Poteau.

A *motion* was made by Dr. Finis Ewing, *seconded* by Dr. J. V. Athey, that the nominations cease and Dr. Woodson be elected by acclamation. The motion *carried*.

The Speaker announced that the next item on the agenda would be the installation of the officers for 1945-1946, and recognized Dr. C. R. Rountree.

Dr. Rountree: "It is with deep regret that we cannot install the incoming President in the proper way but I am sure you will appreciate that our welcome is not any less sincere or enthusiastic. I want to say that there has never been a man who has been more faithful in his work with me and for organized medicine. It gives me great pleasure and privilege to turn over the gavel to him as President of the Oklahoma State Medical Association. I know we are going to have a big year."

Dr. Rountree, President of the Oklahoma State Medical Association 1944-1945 then presented the gavel to the incoming President, Dr. V. C. Tisdal, for 1945-1946.

Dr. Tisdal accepted the gavel and made the following remarks:

"Dr. Charlie, Dr. Tom, other officers and members of the House of Delegates of the Oklahoma State Medical Association, I want to assure you that the past year of all my years of working with the State Association, were the most pleasant, most fruitful years of my life. I have received more inspiration and pleasure than I have ever had before. With those comments I want to present a suggested Program and ask your suggestions.

"We believe it is the consensus of opinion that the Oklahoma State Medical Association should have another active energetic program for the ensuing year. If such a program is vitalized, it will require sacrifice by every member and will also need the enlistment of strong lay personnel. Never before have the opportunities been so great, the challenge so appealing and the results of activity more fruitful for the medical profession than today.

"If we are to meet our responsibilities we must of necessity make a sacrifice of time which is unparalleled in the history of our Association. We must use our finances as never before; we must be sane, reasonable, and realistic in all of our activities—realizing that we cannot accomplish in one year, or even ten years, the goal that is mandatory for us to inaugurate at this time. Small undertakings might be likened to small investments, the return, must of necessity, be meager, but if we lay a program that will bear fruit sufficient to attract attention of the people of our State we can more easily get their ear. In return there must be effort, sacrifice of time, and a united determination to see the program through.

"The Program:

1. Public education
2. Postgraduate education
3. Postwar planning
4. A close fostering of our county societies.

Public Education

"The Press, radio, motion pictures, public speakers, should all be used intelligently to present the importance of scientific medicine to the public. Newspapers and magazines should be furnished with material on medical suggestions in words which will be understood by laymen. Many newspapers of the state would welcome material of this kind and would carry such material as a column from the State Medical Association. Bulletins should also be distributed through the doctors offices.

"The radio should be used as much as possible. The most effective radio programs are systematically conducted. It is found that paid-for time is much more effective than the "hit and miss" method which is used too often by groups such as the Medical Association.

"Many motion pictures are available on medical subjects such as tuberculosis, cancer, crippled children's work. These and other subjects should be presented to schools, civic clubs, and other lay organizations.

"There should be a speaker's bureau in every medical

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society and the members of the medical profession should be available to help to educate civic groups. An outstanding speaker should be hired by the State Association to carry on a program of public education in every community of the state. We should work in connection with the State Health Department and encourage the development of health exhibits in Court Houses or public buildings throughout the state.

Postgraduate Education

"We feel it mandatory to reorganize the postgraduate program of the Medical Association and that the Medical School be designated as a postgraduate center to provide refresher courses for the benefit of the doctors of our state. I understand that this program is now being considered by a special committee of the Medical School. We also feel that the faculty of the School of Medicine should carry such courses to the doctors over the state. We feel it is important that these refresher and postgraduate courses be developed without delay, especially in view of the fact that service men are now returning to the states.

Post War Planning

"Our post war program should be developed for the benefit of doctors in the armed services and should aid them in their readjustment in the various communities of the state. It should also have in mind the readjustment of those physicians who have served at home. This post war program should take unusual interest in the proper distribution of doctors in the remote districts of the state and should take an active interest in seeing to it that the proposed hospital plan will be developed along sound and practical ways.

"It is important that such a program be correlated with the State Health Department and that the medical profession should assume responsibility and assert influence to the end that any hospital or health program will be for the best interests of the people. The recent storms in various parts of the state indicate the importance of health centers and hospitals in the remote districts of the State. The public will look to us in the development of such programs.

County Societies

"The State Medical Association should take interest in the activities of the County Societies and should encourage them to carry out the objectives of the State Association in all of the activities mentioned above. It goes without saying that the people look to their Medical Societies for guidance and it is important that every County Medical Society do everything possible to educate the public in regard to the policies of organized medicine. The State Medical Association should offer programs and any other possible assistance to the local societies in line with the provisions and By-laws of the Constitution of this Association.

"We feel that with the strong support of the law makers of the State and the health program which has been inaugurated, that the State Medical Association has an unusual responsibility, and with the help of all the doctors we should contribute much to the health of the people of the State of Oklahoma."

Dr. Tisdal then stated that Committee appointments would be announced later.

Dr. Tisdal requested that the Speaker ask the House of Delegates to express its opinion of his policies for the next year. The approval was unanimous.

The Speaker asked that those members of the House who intended to stay over and go to the Legislature the following morning, please present their names to the desk. He also announced that there would be a meeting of the Council in the Executive Offices at 2 P. M.

A motion was made by Dr. Carroll Pounders that a vote of thanks be extended by the House to Dr. Rountree, Dr. Lowry and others who have furthered the Associations efforts during the past year. The motion was seconded by Dr. C. E. White and carried.

Dr. Tisdal repeated the plea that all who could, stay over and go to the Legislature the following morning.

The Speaker then recognized Dr. Clinton Gallaher, Shawnee.

Dr. Gallaher said, "As a token of appreciation of his

services and devotion to the Oklahoma State Medical Association and because he is a very grand person, I make a motion that a Resolution be passed by this House commending A. S. Risser for his services as Delegate to the American Medical Association."

The motion was seconded by Dr. Ralph McGill and carried.

The Speaker recognized Dr. J. D. Osborn, Frederick, who said, "Before we adjourn I wish to express a vote of thanks to the Speaker of the House, Dr. George Garrison, for his capable handling of this meeting. He is the best Speaker of the House that we have ever had."

A motion for adjournment was made by Dr. D. H. O'Donoghue, seconded by Dr. J. S. Fulton, and carried.

Dr. Garrison announced that immediately following the meeting, a luncheon, by courtesy of the Oklahoma County Medical Society, would be served to the Delegates in the Empire Room.

Report of Committee on Post War Planning

A report of your Committee on Post War Planning was published in the November, 1943, issue of the Journal, a subsequent report was published in July, 1944, and a subsequent report was made to the Council of the Oklahoma State Medical Association on October 22, 1944.

Since our last report, another questionnaire and letter has been sent to each Oklahoma medical officer in the Armed Forces explaining the provisions of the G. I. Bill, and also to determine the number of doctors who will want to take their postwar training in the State of Oklahoma, what branch of medicine they will want to take it in, and the type and duration of training which they wish. The results of this last questionnaire are as follows:

Total number of doctors who entered the service from Oklahoma is 666. Of those, 31 have returned, and 8 have died in the service.

Two hundred and seven of the last questionnaires have been returned, and of these, 146 expressed a wish for refresher courses, and 140 for residencies. Fifty five were willing to take residencies in small hospitals and 15 were willing to take externships. Sixty three wanted their refresher courses in Oklahoma. Fifty seven wanted their refresher courses in other states. Fifty eight wanted residencies in Oklahoma. Forty seven wanted residencies in other states.

The services most in demand were surgery, with 49 requests for refresher courses and 60 for residencies; medicine, with 28 requests for refresher courses, and 20 for residencies; obstetrics and gynecology, with 16 requests for refresher courses, and 19 for residencies.

According to available estimate, there are approximately 60,000 doctors in the Armed Forces, and roughly 20,000 to 30,000 of these will remain in the Armed Service or Veterans Facilities for a prolonged time, and it is the opinion of this committee that the demand for postwar training among those who return will not be as great as the figures might indicate.

In the Journal of the American Medical Association of March 31, 1945, there was published the most recent results of the questionnaire sent out by the A.M.A. This report includes the results of 21,029 questionnaires returned from doctors in the Service. The conclusions of that report were as follows:

1. Future educational desires of medical officers on duty with the Army, Navy, Public Health Service and Veterans Administration were determined by a study of 21,029 returned questionnaires.

2. Nearly 60 per cent of the group, of 12,534, wanted to take long courses of further training in hospital or educational work. Courses of six months or longer were called long courses, shorter courses were called short courses. About one-fifth of the group, or 4,563, indicated that they wanted to take short courses.

3. There were 3,922 medical officers, or 18.7 per cent of the group who did not want any future training.

4. Requests for short courses included all specialties.

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The largest number of requests were made for the following specialties in order of frequency: internal medicine, surgery, general review, obstetrics and gynecology, pediatrics, otolaryngology and ophthalmology.

5. The ten most popular special fields of training by means of long courses were in order of frequency of request, surgery, internal medicine, obstetrics and gynecology, general review, psychiatry and neurology, pediatrics, orthopedic surgery, ophthalmology, radiology and otolaryngology.

6. Nearly two thirds of the group (63 per cent), or 13,333, expressed a desire to become certified specialists. There were 3,324 medical officers who had been certified by the American specialty boards, or nearly 16 per cent of the entire group. The remainder of the group either did not care to be certified or did not mention their desires.

7. Most of the medical officers, 8,734 men, or nearly 40 per cent, came from private practice to the military services. Twenty-two per cent came directly from internships (4,640), nearly 10 per cent came directly from residencies (2,191) and the remainder came from other types of practice. About 15 per cent failed to answer the question concerning their previous type of medical practice.

8. A comparison of the results of a pilot questionnaire and the present questionnaire was made. Long courses were requested by about one fourth more men in the final questionnaire as in the pilot. The difference was attributed to a change in point of view of medical officers during the interval between the circulation of the questionnaires.

The Post War Planning Committee is cooperating with the Committee on Post Graduate Medical Training of the Oklahoma State Medical Association, the American Medical Association, the University of Oklahoma School of Medicine, and the County Society in an effort to be of help to the service doctors who will return to civilian life. A survey of the State, including hospital facilities and various information on every community has been made and is available to each returning doctor. A tentative curriculum for an eight weeks general refresher course at the University of Oklahoma has been made, and courses will be started when the demands arise. Every effort will be made to supply residencies and fellowships and the kind of training which these men will want and deserve.

Tom Lowry, M.D., Chairman
Claude S. Chambers, M.D.
J. Hobson Veazey, M.D.

Classified Advertisements

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Woman's Auxiliary

The Woman's Auxiliary of the Oklahoma State Medical Association held its last regular meeting in Tulsa April 24-25, 1944, at which time the members were brilliantly entertained under the auspices of the Tulsa County Auxiliary. Following this, four of the Oklahoma members attended the National Convention in Chicago in June. At this meeting in Tulsa, Oklahoma County won the Silver Achievement Tray for the third consecutive time for the most achievements, giving them permanent possession of it.

This year, following the plan of the State Medical Association, the meeting will be limited to members of the Executive Board for the purpose of an election of officers and transaction of business to be held in Oklahoma City April 22, 1945.

The five chapters consisting of 276 members have constantly stressed their war activities as their chief aim, as for example, Tulsa County alone reported 9,243 hours of community service, most of which was primarily of wartime nature. Whereas, Oklahoma County reported 3,854 hours of wartime activity alone, Pottawatomie County 3,936½ hours, and each of our other chapters accordingly.

Secondly, among the primary activities has been the education by our members of various laity, organizations, study clubs, etc., as to the purpose of the Oklahoma State Medical Insurance Plan and the truths concerning socialized medicine. We feel that in this manner we have accomplished much, in both teaching the truth and establishing good will.

As has been previously reported two years ago, the Auxiliary converted its Student Loan Fund into war bonds, buying \$1,000 bond at that time and we have hoped to add to this as finances would permit.

Each of our five chapters have worked diligently on their Hygeia quota, giving us a total of 168 for the state of Oklahoma.

Thus, though this our next regular meeting and many of our membership and lots of our regular social activities have been curtailed, we feel that we have accomplished much during the past year, both in maintaining our membership, Hygeia activity, etc. and most particularly in our wartime activities and I wish to take this opportunity to thank each officer and member for their loyal support and help.

Mrs. C. C. Young, President

Annual Report of Oklahoma County Medical Auxiliary

The Oklahoma County Medical Auxiliary met during the year 1944-45 for five regular meetings, from October to April inclusive, the February meeting being omitted due to severe weather and lack of transportation. At each meeting the members prepared dressings for the Crippled Childrens Hospital, sewed and made new garments and glove cases required, and cut and put together scrap books for the same hospital. A brief business meeting was held at each session, and two specially called Executive Board meetings were held; one September 13th to prepare and plan the year's work, and another one on March 8, 1945 to plan for Election of Officers and transact necessary business.

The chief social affair of the year was a Registration Morning Coffee on September 29 at the home of Mrs. Ray Balyeat. One hundred thirteen ladies attended, 94 being paid and registered members. Later, enough more members joined to bring enrollment to 152 members. The average monthly attendance at the sewing meetings was 32 members. Of the total membership, 18 members were new and 4 were reinstated. Also the Auxiliary was hostess to the wives of the visiting Clinical Conference

guests; first at a dinner in the Rainbow Room and the following day 120 were served at an honor luncheon in the Venetian Room of the Y.W.C.A.

Special projects for the year, in addition to the regular monthly work were: first, a Christmas contribution of 20 articles of staple groceries and \$15.00 in money to care for a United Provident family of five; and secondly, a layette shower in March. In this project there were delivered eight complete layettes to University and Wesley Hospitals and to the Welfare Association. The total work accomplished in dressings and garments for Crippled Childrens Hospital during the year were: compresses—1,300; Sponges—390; glove cases and wrappers—27; osteo dressings—126; hospital gowns—4. The last meeting in April will be devoted to making 20 of these gowns.

The financial report is as follows: from money carried over from 1943-44 and new memberships this year, \$552.64 was paid into the treasury. Besides necessary items of expense to carry on our work, three donations to Red Cross and Community War work were made to the amount of \$135.00. The balance in the treasury April 1 is \$230.38.

The united war work hours, Red Cross Activities of various kinds, teaching and nurses aide hours, etc., came to a grand total of 3,854 hours. The detailed account of this work was charted and mailed to the State Chairman, Mrs. Walter Larrabee of Tulsa. The Hygeia subscriptions were 55 in number. Public Relations Chairman, Mrs. Elsie Kelso presented one program at the March meeting.

Mrs. Walker Morledge.

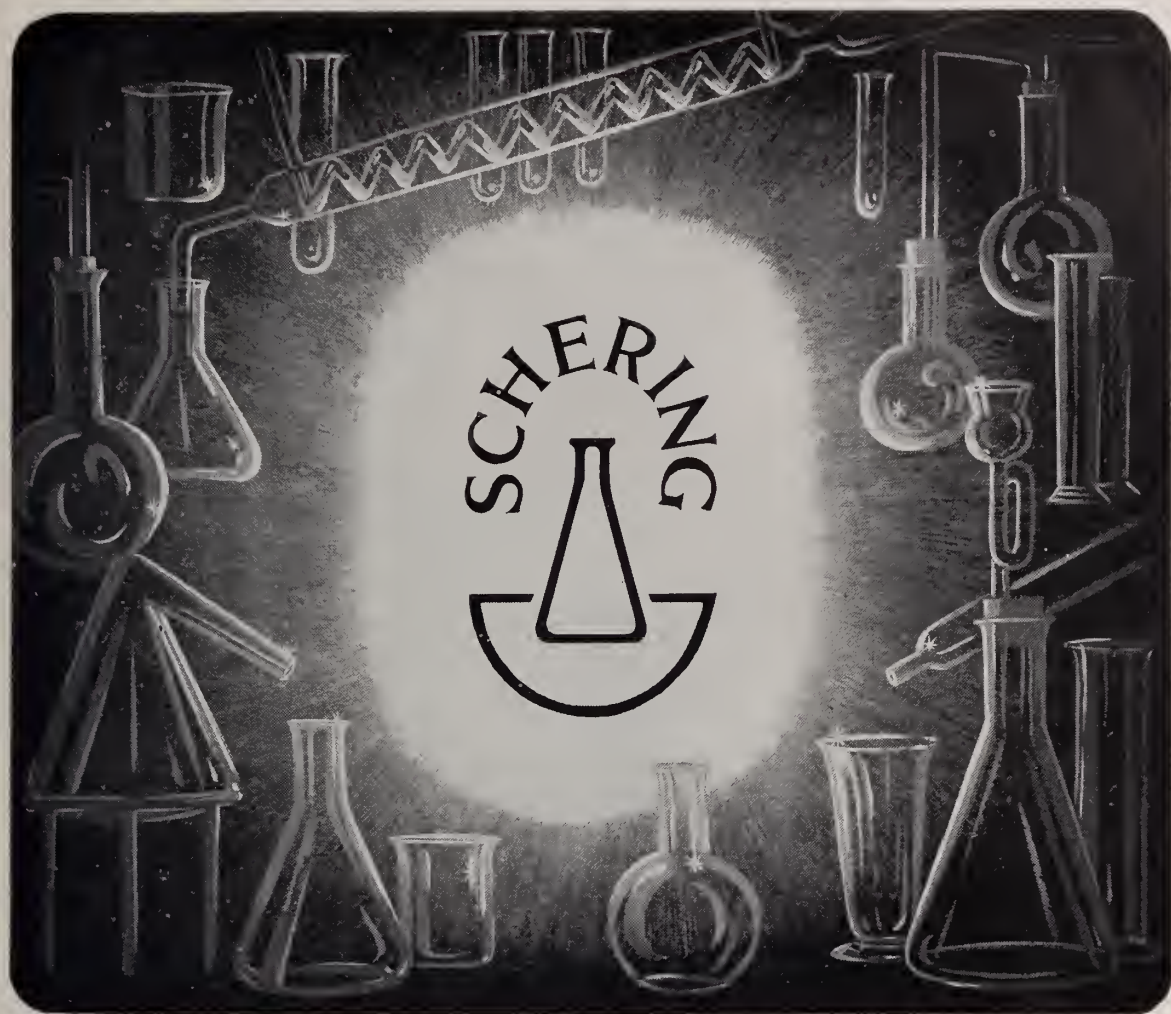
Annual Report of Tulsa County Medical Auxiliary

The officers of the Tulsa County Medical Auxiliary include Mrs. Carl J. H. Hotz—President; Mrs. Charles H. Haralson—President-Elect; Mrs. Frank J. Nelson—Vice-President; Mrs. Logan Spann—Recording Secretary; Mrs. W. R. Turnbow—Corresponding Secretary; Mrs. Donald L. Mishler—Treasurer; Mrs. Allen C. Kramer—Historian; Mrs. James Stevenson—Parliamentarian.

It is with pleasure that I review for you the activities of the Auxiliary to the Tulsa County Medical Society, and I wish to thank the officers and committees, as well as all of the members, for their splendid cooperation in maintaining our organization during such a trying time in the history of our nation.

Our membership for this year is 106 active members, of which 8 members whose husbands are with the armed forces are exempt from all dues. The Auxiliary has, however, paid the State and National dues of these 8 members from our treasury. We also have 20 honorary members, some of whom attend regularly and are quite active in our organization. Our meetings are held monthly in the homes of our members, with six hostesses serving luncheon. Preceding the meetings, an executive board meeting is held, at which plans, publicity and programs are discussed.

Our first meeting each fall is the Morning Coffee, which was held this year in the home of Mrs. John Perry, on October 3, 1944. There were 47 members present and the yearbooks were distributed by our President-Elect, Mrs. Charles H. Haralson. The November meeting was in charge of Mrs. I. H. Nelson, Chairman of the Public Relations Committee who presented, as speaker, Mrs. George Garrison of Oklahoma City, who gave an interesting and timely talk. Special guests were the presidents of the following Tulsa Clubs: Panhellenic, A.A.U.W., Garden Club, Dental Auxiliary, Nurses' Association, Federation of Women's Clubs, D.A.R., P.E.O., P.T.A. Council, League of Women Voters, and the College Club. Our December meeting was a beautiful Christmas Tea with the members of the Dental Auxiliary as guests. Mrs. James Stevenson presented a review of Barbara Wollcott's book, "None But a Mule." The January meeting was omitted, due to the fact that the regular meeting date was January 2 and the board felt that the



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attendance would not warrant holding a meeting. At the February meeting Mrs. C. H. Haralson gave a talk on "How to Meet the Returning Soldier." The March meeting was held and the attendance was excellent. Members whose husbands are in the service gave talks on personal experiences encountered while traveling and, or staying at home. At the April meeting, Sister Immaculata of the Monte Cassino School for Girls presented students in a skit entitled "All on a Summer's Day." The program for the May meeting will be most interesting, with Dr. Margaret Hudson presenting "What's New in Medicine." The last meeting of the year, a Morning Coffee, will be held in June, at which time the new officers will be installed. The Tulsa Federation of Music Clubs will present a musical program at that time.

The Committee Activities are as follows: The Social Committee arranged the coffee in October and also will have charge of the last meeting in June. The Philanthropic Committee had for their project the annual toy shower for the Children's Christmas Parties at the hospitals, and they presented 24 toys to St. Johns and 24 toys to Hillcrest Memorial Hospitals, 18 of which were donated at the December meeting, the balance purchased with money donated for that purpose. This Committee also submits to the Auxiliary for approval the upkeep of the loose-leaf book on Medicine by Tice, for the Doctor's Library, in the annual amount of \$5.00, which expenditure was approved at the April meeting for this year. The Public Relations Committee was responsible for the guest speaker from Oklahoma City in November, to which the various local club presidents were invited. This Committee is continuing the dissemination of Health Bulletins at the County Courthouse. The Courtesy Committee has functioned effectively. Contributions of \$6.00 were given to the Tulsa D.A.R. for the Blood Plasma Bank in memory of Dr. Ned R. Smith and Dr. J. B. Gilbert. Also, donations of \$6.00 were made to the Hillcrest Memorial Building Fund in memory of Mrs. Louella Walker and Mrs. Edna Gilbert. Also a donation of \$3.00 was made to the Endowment Fund in Ophthalmology of the Medical Society Library, in memory of Dr. Albert W. Roth. The Hygeia Committee placed 59 six month subscriptions in the various schools at a cost of \$39.60 and secured 18 one year subscriptions. The Telephone Committee has been very diligent and there has been an average attendance of 38 at the meetings this year. The Legislative Committee has kept us informed at all times of pending legislation which may affect the health of our community. The War Aid Committee, under the chairmanship of Mrs. Hugh Perry, has prepared quite an extensive report of our war activities as follows: (This report is abstracted): U. S. War Bond Drive—168 hrs.; Hospital Service—1,000 hrs.; Community Service—957 hrs.; Hostesses for Service Centers—1,680 hrs.; Canteens—250 hrs.; Red Cross—4,178 hrs.; Civilian Defense—262 hrs.; Group Leadership—528 hrs.—making a total of 9,243 hrs.

The Auxiliary participated in the Fifth War Loan Drive in June, 1944 and were responsible for the sale of \$45,000.00 in bonds. A committee to canvas the Medical Arts Bldg., during the Red Cross Drive in March was successful in securing donations of \$2,534.75.

Copies of the Constitution and By-Laws, as amended

to January 1, 1945, were prepared by the president, and placed in the hands of the President-Elect, the Parliamentarian and in the Secretary's record book.

At the April meeting, an appeal was given for the members individually to support the Maternal Health League in the City of Tulsa, and an opportunity was given each member to join the league. Also at the April Meeting, annual reports were given and the following 1945-46 officers were elected. Mrs. Charles H. Haralson—President; Mrs. D. W. LeMaster—President-Elect; Mrs. W. A. Dean—Vice-President; Mrs. Ellis Jones—Recording Secretary; Mrs. Eric White—Corresponding Secretary; Mrs. Ralph McGill—Treasurer; Mrs. J. W. Childs—Historian; Mrs. C. C. Hoke—Parliamentarian.

To commemorate Doctor's Day, which is March 30, Mrs. D. W. LeMaster prepared a Resolution to the members of the Tulsa County Medical Society, expressing our appreciation of their efforts. Due to wartime restrictions, there will be no State convention this year, but the State President is calling a meeting of the State Executive Board and the County Presidents in Oklahoma City on April 22, in order that new officers may be elected for the coming year.

During the year, the Auxiliary suffered the loss of two of its members, Mrs. Edna Gilbert and Mrs. Louella Walker, and of three of our outstanding doctors, Dr. Ned R. Smith, Dr. J. B. Gilbert, and Dr. Albert W. Roth.

The Auxiliary is definitely playing an important part in the health education and the dissemination of health information in our community, and I feel deeply grateful for the privilege of serving as its president during the past year.

Mrs. Carl J. H. Hotz.

Annual Report Pottawatomie County Medical Auxiliary

The Auxiliary to the Pottawatomie County Medical Society is completing the 38th year of activity. The present officers include Mrs. Clinton Gallaher, President; Mrs. J. M. Byrum, Vice-President; Mrs. Charles W. Haygood, Secretary-Treasurer. The new officers include, Mrs. E. Eugene Rice, President; Mrs. Charles W. Haygood, Vice-President; Mrs. Frank Keen, Secretary-Treasurer. The membership consists of 21 members with 17 being eligible for membership in the State Auxiliary.

Of the 19 subscriptions to Hygeia sold, nine of them were placed in the City Schools of Shawnee, Oklahoma.

The Auxiliary has a total of 3,936½ hours served in war activities as follows: promotion and sale of U. S. War Bonds and Stamps—10 hrs.; Elks Dances for Service men—35 hrs.; Rationing Board—10 hrs.; Red Cross knitting and surgical dressings—2,785½ hours; Red Cross home service—1,046 hrs.; Red Cross War Fund Drive—50 hrs. Mrs. R. M. Anderson is County Chairman of Red Cross Surgical Dressings; Mrs. C. C. Young is WAVE Recruiter and Red Cross Home Service Worker; Mrs. Clinton Gallaher is Red Cross Home Service Worker and Mrs. H. E. Hughes is Assistant Chairman of Red Cross Home Service and Chairman of Activities of Army and Navy women. Mrs. Charles F. Paramore is Sr. Chairman of the Youths Recreational Center. Some of the members helped with Well Baby Clinics held each month.

Mrs. Clinton Gallaher.

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Annual Report Pontotoc County Medical Auxiliary

Pontotoc County Medical Auxiliary has 14 active members and one honorary member. Mr. Fred Brydia, husband of Dr. Catherine Brydia, participates in the social functions, doing his share of the work and chores. We have not had a formal program this year or regular meetings but have met a sufficient number of times to transact business. At our last meeting it was decided to carry the old officers over for the coming year. Mrs. Lane resigned as treasurer and Mrs. Needham was elected. With that exception the list is the same. Our social functions have consisted of a Thanksgiving Dinner for the doctors which was well attended.

In the past few months the Murray County Society has become incorporated into the Pontotoc County Society. The doctors wives from Murray County have been invited to affiliate with our Auxiliary and will do so when there is time for a formal meeting with them.

Our members are busy with the war effort or active helping their husbands in their offices. Mrs. Cummings, Mrs. Lewis, Mrs. Welborn and Mrs. Lane all work full or part time. Mrs. Dean is on full time duty as a nurse at Valley View Hospital and rendering a much needed service at great personal sacrifice. Mrs. Lane has been accepted for entrance into Oklahoma Medical School beginning with the summer term. Mrs. Gullatt is Director of Nurses Aid Courses for this County and President of her P.T.A. Mrs. McBride is Price Panel Assistant for O.P.A. Mrs. Needham is Chairman of County Red Cross. Mrs. Burns is a teacher in the Stonewall schools. Individual members have worked on Red Cross drives and knit and sew for the Red Cross program and most members are regular contributors to the Red Cross bandage program although we have not officially sponsored any of the work as a group.

Mrs. Sugg and Mrs. Cummings have become grandmothers in the recent past and Mrs. Mayes is proud of her new daughter, born March 31, 1945, at Wesley Hospital, Oklahoma City.

We plan to resume our regular meetings and programs as soon as the war and other activities permit. In the meantime we plan to keep our chapter functioning and be ready for the post-war, whatever it may bring.

Mrs. Ollie McBride.

Annual Report of Cleveland County Medical Auxiliary

Twenty doctor's wives are eligible for membership with a paid membership of nine. Eight meetings have been held with an average attendance of 5.5 per cent. Seventeen subscriptions to Hygeia have been sold. Dues paid to the State and National Auxiliaries amounted to \$4.50.

The following is a record of hours served by the members in War Service work; grey ladies—50 hrs.; bandages—292 hrs.; Nutrition—1 yr. postgraduate work on Master's degree; Canteen—99 hrs.; sewing and knitting—10 hrs.; home nursing—56 hrs.; doctor's assistant—13 months full time; war service program chairman—40 hrs.; committees in clubs and churches—21½ yrs. full time.

The following officers were elected for 1945-46: Mrs. M. M. Wickham—President; Mrs. Phil Haddock—Vice-President; Mrs. Jim Haddock—Secretary; Mrs. D. W. O'Leary—Treasurer.

Mrs. F. T. Gastineau.

In Memoriam

Mrs. Louella Walker was born in Bancroft, Michigan, and was a graduate nurse from Harper Hospital, Detroit. She was a resident of Oklahoma for fifteen years, and was very active in the Health Department of the P.T.A. and the Medical Auxiliary. She passed away in July, 1944. Surviving her are the husband, Dr. W. A. Walker, and one son, Bill.

Mrs. Edna Gilbert, widow of Dr. J. A. Gilbert, passed away in December, 1944. Surviving is her mother, Mrs. Wilson. Mrs. Gilbert had been an active and faithful member of the Auxiliary.

MEDICAL ABSTRACTS

KOBRAK, F. Principles of sensitivity and efficiency of the ear. The Journal of Laryngology and Otology, London, volume 59, page 171-182, May 1944.

Sensitivity is the basic and elementary physiological faculty of a sensory organ to perceive specific impressions. In case of hearing it is pure tone sensitivity; in case of the vestibular functions it is pure directional or positional sense. Efficiency is a more complex faculty.

Auditory efficiency may be purely cochlear, or it may be panaural which is a combination of cochlear and extracochlear functions. The cochlear efficiency consists of the constituent elementary sensitivities of pitch; the panaural efficiency consists of the net results of cochlear and extracochlear functions, interrelated between pure tone sensitivities and muscular reflexes in the ear, together with psychological factors, such as concentration, fatigue, etc.

Vestibular efficiency shows interrelated directional functions between the semicircular canals of the ear, also a certain amount of equilibration between the functions of the two sides of vestibular system.

The author points out that in examination of the ear

one should keep in mind that sensitivity is not identical with efficiency. Our diagnostic tools are not testing necessarily both faculties. There is a basic difference between audiometry and tuning fork tests. The audiometer tests pure tone sensitivity while the uninterrupted tuning fork test provides, in addition to the threshold of sensitivity, information about the efficiency of hearing over a certain period of time in the specific conditions of the decaying tuning fork, that is, hearing during a period of diminuendo. The complex function of diminuendo period hearing of tuning forks should be considered as a test of efficiency.

The efficiency of the vestibular nerve is closely associated with the eye muscles, i.e. vestibular nystagmus. Nystagmus regarded as a test of efficiency is quite reasonable, as the phenomena of vestibular nystagmus are in conformity with those of optical nystagmus, and the latter is certainly a phenomenon of efficiency, of visual adaptability to the absolute or relative movement of surrounding objects.

The vestibular nerve is in a state of permanent stimulation, even when the body is at rest; there is a posi-

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tional tonus in the utricle. Stimulation of the vestibular nerve is followed not by fatigue, but by an increased residual tonus detectable by change of muscular tone, particularly in the external muscles of the eye. A sub-threshold stimulation may not produce nystagmus or any other muscular response in the eye muscles; but if the other ear also receives the same subthreshold stimulation, a nystagmus is produced. This is explained as a state of dormant nystagmus based upon the residual tonus remaining from the previous stimulation of the other ear.—*M.D.H., M.D.*

OBSERVATIONS ON BATTLE FRACTURES OF THE EXTREMITIES. Oscar P. Hampton and Joe M. Parker. *Surgery*, Vol. XV, page 869. June, 1944.

This report covers a study of definite care for approximately 1,400 men with fractures of the extremities due to high-explosive or bullet wounds. Treatment was rendered in a general hospital, which was functioning actively in a zone of communications at a base for a period of eight months. Approximately 98 per cent of the injuries were given first aid and definite treatment in forward evacuation or surgical hospitals. For the most part, the initial care was considered to be good. Sulfanilamide had been used in most instances, either in the wound or orally, or both; within an average of eight hours, 92 per cent of a group of 500 had this prophylactic therapy. In 1,400 cases of compound fractures secondary to high-explosive or bullet wounds, debridement was sufficiently good in the forward medical installations to prevent sepsis in all but fifteen to eighteen cases.

The authors have recommended the filling of the initial compound wound loosely with petroleum-jelly gauze. They have strongly and wisely advised against tight packing of the wound.

Primary internal fixation in compound fractures caused by high explosives is considered unwise, and will fail in most instances. Pins for skeletal traction or for plaster fixation, which were inserted before the patient reached the base hospital, produced a high incidence of complications. Padded casts were found to be more satisfactory than primary skin-tight plaster.

The authors are enthusiastic about the method of cast traction in the prevention of deformity and osteomyelitis in compound fractures of the tibia and fibula.—*E.D. M. M.D.*

DAVIDSON, F. W. Does chronic sinusitis cause bronchiectasis? The Annals of Otology, Rhinology & Laryngology, volume 53, page 849-853, December 1944.

Numerous articles in the medical literature support the view that sinus infections cause bronchiectasis. The author challenges this statement. The frequent coincidence of two diseases in the same patient should not be taken as proof that one causes the other, but it should suggest that both are of the same causation.

The author analyzed 50 patients who had bronchiectasis, and the histories of 50 patients with chronic suppurative sinusitis of at least one year's duration who had no bronchopulmonary symptoms. The allergic basis of these affections was also examined by the author. He found that 80 per cent of the bronchiectatic patients were hypersensitive and 66 per cent had sinusitis. Of the patients who had both sinusitis and bronchiectasis 33 were allergic. This indicates that the excessive mucosal edema found in hypersensitive individuals predisposes them to the development of chronic sinusitis as well as to bronchiectasis.

Already in 1938, Watson and Kibler found allergic manifestations in the great majority of their patients with bronchiectasis. Mucosal edema is probably the chief factor responsible for the atelectasis which leads to the development of bronchiectasis. There are thousands of children who each year simultaneously develop acute sinusitis and bronchopneumonia. It is the author's impression that the hypersensitive individuals frequently fail to recover completely from these acute infections and have as sequels chronic sinusitis and bronchiectasis.

Mucosal edema of only one mm. thickness reduces the lumen of a 6 mm. bronchus to 44 per cent of its normal area; the same amount of edema in a 33 mm. bronchus reduces the lumen to 11 per cent of its normal area. This explains why atelectasis and resultant bronchiectasis develops so frequently in childhood in hypersensitive individuals. It also explains the preponderance of bronchiectasis in the left lower lobe where the bronchi are narrower than in the corresponding lobe on the right side.

Bronchoscopic aspiration is of unquestionable value in removing viscid obstructing exudate, but aspiration cannot remove edema of the bronchial mucosa. We should, therefore, utilize additional therapeutic measures directed at reducing the mucosal edema at the time of the acute bronchopulmonary infection. Ephedrine by oral or sub-

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entaneous administration does help to control mucosal edema during acute respiratory infections in hypersensitive individuals but better methods are desirable.—*M.D.H., M.D.*

A METHOD FOR FUSION OF THE WRIST. Paul C. Colonna. *Southern Medical Journal*, Vol. XXXVII, page 195. 1944.

Indications for fusion of the wrist include; chronic inflammatory lesions involving the wrist joint, tuberculous or non-tuberculous, that have caused the wrists to assume a flexed attitude; spastic paralysis with marked flexion deformity of the wrist; conditions following infantile paralysis in selected cases; and severe traumatic arthritis. In some instances muscle transplantation of the flexor muscles of the wrist into the extensors may be desirable preceding fusion. The operation is not done generally before epiphyseal closure is shown by reontogram, at sixteen to eighteen years of age. If fusion becomes necessary before this age period, operative closure can be effected.

At operation, the dorsum of the lower end of the radius, the carpal bones, and the proximal third of the

second and third metacarpal bones are exposed. A bed is prepared for a rib graft by making clefts in the bases of the second and third metacarpals, and in the lower end of the radius. The graft is removed, with oblique cuts, from the lateral chest wall, on the same side as the wrist to be fused. The natural curve of the rib, when the graft is firmly embedded in its prepared bed, usually gives the desired degree of cocked-up position to the wrist. The graft is split longitudinally with an osteotome and one-half is fitted, marrow side down, into the denuded bed in the wrist joint. The other half is sometimes used for chips, to be packed in around the graft.

A circular plaster holds the wrist and arm in position, and bony union can be demonstrated at eight to ten weeks. Support in the cocked-up attitude is continued for at least sixteen weeks following operation. The patient is ambulatory after the first week.—*E.D.M., M.D.*

ATKINSON, Miles. Tinnitus aurium: observations on Rhinology, and Laryngology, its nature and control, volume 53, page 742-751. The Annals of Otology, December 1944.

The nature and causation of tinnitus is still a puzzle

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for otologists. The question has been studied exclusively from the otological angle, while the more general neurological outlook has been largely disregarded. The symptom of tinnitus is the homologue of paresthesia in the peripheral sensory apparatus and can be produced by various stimuli, mechanical and occupational, or by internal factors, such as the effect of chemicals and drugs, or of infectious diseases and metabolic disturbances.

In a number of tinnitus cases there cannot be found any satisfactory explanation or stimulus. Tinnitus is an auditory paresthesia; as such it may vary from a slight and short-lived sensation to a constant and even agonizing distress, from a hiss in the ear to a constant roar of great intensity which renders life a burden. Division of the cochlear nerve, the suggested operation for this condition, will often not relieve the patient of his noises.

Tinnitus is symptomatic of an active pathological disturbance in the auditory tract, and in the beginning at least in the infrasegmental division. If sustained, it is a warning of impending deafness. The symptom of tinnitus is always combined with some degree of deafness, even if only a temporary veiling during the short-lived bouts of tinnitus to which everybody is at times subject. It is the result not of a lesion in the cochlea but of a lesion in the nerve itself, of a neurotic disturbance probably of biochemical nature conditioned by some local metabolic change. It may be considered a peripheral neuropathy of the auditory nerve.

Observations show that the symptoms of tinnitus may have its origin in a vascular disturbance involving the cochlear nerve. This is the same basis which has been accepted for the explanation of Meiere's disease. As in that disease, in tinnitus also one experimented with vasodilator drugs in treatment. The author used nicotinic acid almost exclusively. He treated 175 patients who complained of tinnitus.

The patients received nicotinic acid, which can be given by all routes, intravenous, intramuscular and oral, and should be given by them all and in that order. It can be used over a long period of time without producing tolerance, and must be used for a long time if satisfactory results are to be obtained. Clinically it appears to act with especial effect upon the vessels of the head.

In the author's series, 15 per cent of the patients were completely relieved, while 48 per cent were definitely improved. The greatest percentage of relief or improvement has been obtained in cases of conductive deafness (85 per cent of 45 cases).—*M.D.H., M.D.*

GREENFIELD, Samuel D. (et al.) The use of penicillin in otorhinologic infections; report of five cases with recovery. *The Laryngoscope*, volume 55, page 20-27, January 1945.

The reported five cases are interesting examples of the great curative effect of penicillin. The first is a case of cavernous sinus thrombosis resulting from a furuncle in the nose. The blood cultures showed hemolytic streptococcus. The patient was given penicillin in the amount of 500,000 units in six days, together with heparin in the amount of 900 mg. This was followed by recovery without operation.

In another patient, osteomyelitis developed after a frontal sinus operation; there was an extensive epidural

abscess and a spreading acute osteomyelitis of the frontal bone. She was given 15,000 units of penicillin intramuscularly every four hours throughout day and night for one week; the total amount of penicillin administered was one million units. Soon, the temperature reached normal level, and the spreading infection was halted.

In two cases of surgical mastoiditis, penicillin medication spared the patients the necessity of surgical intervention. In the fifth case, subperiosteal abscess developed as a complication of middle ear inflammation in a young infant. Ordinarily, such a case would call for a mastoid operation. Yet, under penicillin treatment the edema and tenderness over the mastoid and zygoma disappeared and the temperature became normal.—*M.D.H., M.D.*

E.D.M. M.D.Earl D. McBride
M.D.H., M.D.Marvin D. Henley

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—*Alexander Pope; A Physician's
Anthology of English and American
Poetry*, p. 117.

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Atoka-Coal.....	C. D. Dale, Atoka	J. S. Fulton, Atoka	
Beckham.....	G. H. Stagner, Erick	O. C. Standifer, Elk City	Second Tuesday
Blaine.....	Virginia Curtin, Watonga	W. F. Griffin, Watonga	
Bryan.....	W. A. Hyde, Durant	W. K. Haynie, Durant	Second Tuesday
Caddo.....	C. B. Sullivan, Carnegie	P. H. Anderson, Anadarko	
Canadian.....	P. F. Herod, El Reno	A. L. Johnson, El Reno	Subject to call
Carter.....	J. L. Cox, Ardmore	H. A. Higgins, Ardmore	Second Tuesday
Cherokee.....	P. H. Medearis, Tahlequah	W. M. Wood, Tahlequah	First Tuesday
Choctaw.....	O. R. Gregg, Hugo	E. A. Johnson, Hugo	
Cleveland.....	Iva S. Merritt, Norman	O. M. Woodson, Norman	Thursday nights
Comanche.....	W. F. Lewis, Lawton	W. C. Cole, Lawton	
Cotton.....	G. W. Baker, Walters	Mollie F. Scism, Walters	Third Friday
Craig.....	Lloyd H. McPike, Vinita	J. M. McMillan, Vinita	
Creek.....	C. R. McDonald, Mannford	Philip Joseph, Vinita	
Custer.....	T. A. Boyd, Weatherford	W. H. Smith, Clinton	Third Thursday
Garfield.....	P. W. Hopkins, Enid	John R. Walker, Enid	Fourth Thursday
Garvin.....	Marvin E. Robberson, Wynnewood	John R. Callaway, Pauls Valley	Wednesday before Third Thursday
Grady.....	Roy E. Emanuel, Chickasha	Rebecca H. Mason, Chickasha	Third Thursday
Grant.....	I. V. Hardy, Medford	F. P. Robinson, Nash	
Greer.....	R. W. Lewis, Granite	J. B. Hollis, Mangum	
Harmon.....	W. G. Husband, Hollis	R. H. Lynch, Hollis	First Wednesday
Haskell.....	William Carson, Keota	N. K. Williams, McCurtain	
Hughes.....	H. A. Howell, Holdenville	Imogene Mayfield, Holdenville	First Friday
Jackson.....	C. G. Spears, Altus	E. A. Abernethy, Altus	Last Monday
Jefferson.....	F. M. Edwards, Ringling	J. I. Derr, Wanrika	Second Monday
Kay.....	Dewey Mathews, Tonkawa	G. H. Yeary, Newkirk	Second Thursday
Kingfisher.....	B. I. Townsend, Hennessey	A. O. Meredith, Kingfisher	
Kiowa.....	J. P. Brann, Hobart	William Bernell, Hobart	
LeFlore.....	Neeson Rolle, Poteau	Rush L. Wright, Poteau	
Lincoln.....	U. E. Nickell, Davenport	C. W. Robertson, Chandler	First Wednesday
Logan.....	J. L. LeHew, Jr., Guthrie	J. E. Souter, Guthrie	Last Tuesday
Marshall.....	J. L. Holland, Madill	J. F. York, Madill	
Mayes.....	S. C. Rutherford, Locust Grove	B. L. Morrow, Salina	
McClain.....	J. E. Cochrane, Byars	W. C. McCurdy, Jr., Purcell	
McCurtain.....	J. T. Moreland, Idabel	R. H. Sherrill, Broken Bow	Fourth Tuesday
McIntosh.....	J. Howard Baker, Eufaula	Wm. A. Tolleson, Eufaula	First Thursday
Muskogee-Sequoyah			
Wagoner.....	H. A. Scott, Muskogee	D. Evelyn Miller, Muskogee	First Monday
Noble.....	D. F. Coldiron, Perry	Jess W. Driver, Perry	
Okfuskee.....	W. P. Jenkins, Okemah	M. L. Whitney, Okemah	Second Monday
Oklahoma.....	Gregory E. Stanbro, Okla. City	Ben H. Nicholson, Okla. City	Fourth Tuesday
Okmulgee.....	W. M. Haynes, Henryetta	J. C. Matheney, Okmulgee	Second Monday
Osage.....	G. K. Hemphill, Pawhuska	C. R. Weirich, Pawhuska	Third Monday
Ottawa.....	P. J. Cunningham, Miami	L. P. Hetherington, Miami	Second Thursday
Pawnee.....	E. T. Robinson, Cleveland	R. L. Browning, Pawnee	
Payne.....	Haskell Smith, Stillwater	A. C. Reding, Stillwater	Third Thursday
Pittsburg.....	L. N. Dakil, McAlester	A. R. Stough, McAlester	Third Friday
Pontotoc-Murray.....	Ollie McBride, Ada	R. H. Mayes, Ada	First Wednesday
Pottawatomie.....	Chas. W. Haygood, Shawnee	Clinton Gallaher, Shawnee	First and Third Saturday
Pushmataha.....	John S. Lawson, Clayton	B. M. Huckabay, Antlers	
Rogers.....	K. D. Jennings, Chelsea	Chas. L. Caldwell, Chelsea	Third Wednesday
Seminole.....	A. A. Walker, Wewoka	Mack I. Shanholtz, Wewoka	Third Wednesday
Stephens.....	W. K. Walker, Marlow	E. H. Lindley, Duncan	
Texas.....	R. G. Obermiller, Texhoma	Morris Smith, Guymon	
Tillman.....	W. A. Fiqua, Grandfield	O. G. Bacon, Frederick	
Tulsa.....	H. A. Ruprecht, Tulsa	E. O. Johnson, Tulsa	Second and Fourth Monday
Washington-Nowata.....	J. V. Athey, Bartlesville	S. A. Lang, Nowata	Second Wednesday
Washita.....	A. S. Neal, Cordell	James F. McMurphy, Sentinel	
Woods.....	O. E. Templin, Alva	I. F. Stephenson, Alva	Last Tuesday Odd Months
Woodward.....	Roy Newman, Shattuck	C. W. Tedrowe, Woodward	Second Thursday

*(Serving in Armed Forces)

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Common Eye Conditions Among Military Men*

W. W. SANGER, M.C.,

CAMP GRUBER, OKLAHOMA

The eye problems encountered in the army are different from those found in private practice. The treatment is not so different, but the evaluation of disability involves a greater responsibility. Decisions must be made as to reclassification and reassignment, return to active duty, foreign duty, combat duty, hospitalization or discharge from the army.

As combat weapons, combat areas and most all army conditions are constantly changing — so must all medical corps regulations be fluid and flexible. Eye regulations for induction have remained fairly constant. Minimum standards for induction — 20/400 in each eye correctible to 20/40 in each eye — or 20/100 in one eye correctible to 20/20 (the other eye can be blind or artificial). Now, all cases meeting the minimum requirements are classed for general duty. However, when it seems reasonable to reclassify and reassign a man from combat duty to an inside job where excellent vision is not a necessity, this can be easily done by a board of three medical officers, including the ophthalmologist. Defects such as the following are non-acceptable for induction (a) Disfiguring cicatrices (b) pronounced exophthalmous (c) chronic keratitis (d) any active disease of retina, choroid or optic nerve (e) detachment of the retina (f) Nystagmus (g) glaucoma (h) Diplopia (unless mild in degree) (i) abnormal condition of eyes due to brain disease (j) Trachoma and Tumor of the orbit (k) permanent or well marked strabismus of a severe degree.

In the fixed-hospitals of non-combat zone

refractions are a big problem. Early in the training period an eye-survey is made in each unit. It includes those who wear glasses, those who think they may need glasses and those whose vision is considered inadequate. It can be readily understood that this can easily take in 25 per cent of many organizations. The men are very willing to undergo an eye examination at no personal expense that may reveal a defect which they have wondered about or one which may exist and allow some disability — and on the other hand it may relieve them from a half day of tiring drills. At random, the cards of 1,000 men (2,000 eyes) sent to the clinic for refraction were checked for vision without glasses.

3.3 per cent had 20/15 vision
20.5 per cent had 20/20 vision
15.7 per cent had 20/30 vision
11.0 per cent had 20/40 vision
13.2 per cent had 20/50 vision
0.3 per cent had 20/60 vision
10.4 per cent had 20/70 vision
9.1 per cent had 20/100 vision
9.9 per cent had 20/200 vision
3.6 per cent had 20/400 vision
2.5 per cent had less than 20/400 vision
0.1 per cent had light perception
0.3 per cent had no light perception

Although a large per cent have good vision a cycloplegic refraction is done in most all cases because of symptoms of headache, blurring, vertigo, diplopia, "spots" and nyctalopia. Many of the men examined (especially the negroes) having vision from 20/200 to 20/40 will be found to have 20/20 vision

*Delivered Tuesday, April 25 before the Section on Eye, Ear, Nose and Throat at the Annual State Meeting, Tulsa.

under cycloplegic with a plus or minus 25 prism sphere.

During 1943 (6,254) refractions were done at this station. 5,354 of these were given a prescription for glasses. Standards for issuing spectacles have had to be changed several times. The first regulation of 1942 provided that spectacles could be ordered for anyone who in the opinion of the refracting officer needed glasses. This was treated too liberally. In April 1943 glasses were limited to those requiring a correction of more than one diopter in the meridian of greatest error. Of course, there is no regulation against buying and wearing civilian spectacles. Since February 1944 the issuance of spectacles is limited to (a) individuals having a visual acuity of worse than 20/100 in either eye (b) to other individuals who, in the opinion of the refracting medical officer require spectacles for the efficient performance of their military duties — regardless of visual acuity. If care is not exercised this can be treated too liberally. All personnel entitled to glasses are issued two pair (except prisoners of war who are issued one pair). Individuals, under oversea orders, having binocular vision of 20/70 or worse, or those requiring a bifocal are issued the gas mask type spectacles for inserting in the eye pieces of the gas masks. The lenses are supported by a "U" shaped wire frame which can be compressed and inserted inside the eye pieces. The American Optical Company has the government contract for the spectacles, commercial type. These glasses are usually supplied in from one to three weeks but can be delivered in twenty-four hours. The Gas Mask spectacle contract is held by the Riggs Optical Company. These glasses require about ten days for delivery.

The prisoners of war under the rules of the Geneva Conference (which the Red Cross assures us the Germans are following) are given the same treatment afforded our soldiers. These have no particular disease except they seem to run to the high hyperopic states. Many of them have 20/20 vision yet refract from \pm 4.00 to \pm 8.00 under cycloplegic examination. They usually have been wearing full correction and are not comfortable without it. When the German-prisoners are myopic—than tend to be markedly so. One individual refracted -13.00 sphere in one eye and -17.00 in the other. He stated he was not drafted but was accepted after his third attempt to enlist.

The acute infectious cases are about the same as those seen in civilian life. There are less corneal ulcer and Uveitis cases. During the past year 2,039 eye cases were examined and treated. These included the average number of hordeola and chalazia. About two

to three cases of pterygium are transplanted each week. Two cases have been noted with four pterygia — ie. in two on each eye. Both cases were Mexicans from New Mexico.

Conjunctivitis, acute catarrhal type, is an ever-present condition among troops, but to date has never gotten to epidemic form. We average two or three new cases a day. They are treated with one per cent Ag NO₃ to the lids — hot compresses advised and they are given a one-half ounce bottle of a one-fifth per cent Zn SO₄, boric acid and adrenalin solution which is to be used four or five times daily. They rarely return for further treatment although they are advised to do so in four days if symptoms persist.

Soldiers in training are hospitalized much oftener than necessary for civilians. The soldiers cannot be left in bed or as semi-invalids to loaf around the barracks. They must be able to do full duty at all times, or be hospitalized. The conjunctivitis cases are not admitted to the hospital unless complicated by ulcer or chronicity.

Chronic marginal blepharitis cases are seen occasionally. These cases are very resistant to all forms of known treatment (combined treatment of ophthalmology, dermatology and allergy departments). Most are treated and carried along on an inside job while a few of the more serious ones are discharged from the army.

Only four cases of trachoma have been found. These were given a course, or courses, of sulfanamide and separated from the service. One of the typical cases of trachoma was in a negro from New York City. One of the cases responded poorly to treatment.

Injuries are quite frequent. One or two cases of corneal abrasion are seen daily from running into twigs and brush while on night maneuvers. Three cases of perforation of the globe with traumatic cataract have been encountered in the past fifteen months. None of these lost the eyeball.

Land-mines are booby-traps are a constant source of danger to the eyes of troops in training. In one ten-day period fifteen eye cases were treated for blast injuries. Three cases have required enucleation. In one case a sergeant, a piece of copper shell case 6 x 18 mm. was found in the periorbital fat behind the globe, having gone through the cornea and the posterior pole of eyeball. One twenty-seven year old 2nd Lieutenant had the right eye ruptured beyond any hope of vision. The left anterior chamber was filled with blood and the cornea lacerated. Atropine should not be used in these cases because of the danger of glaucoma — but homatropine is permissible after a day or two to break down posterior synechia. In this case blood absorbed enough on the third day to see that

no traumatic cataract was present. He is now in a general hospital under observation. In another case of booby-trap blast, a lieutenant who was wearing myopic lenses received a severe laceration of cornea at the limbus with much intraocular hemorrhage. One or two small pieces of glass were removed from the corneal wound. On the third day pain became pronounced and a paracentesis and irrigation of anterior chamber was done with some relief. He was transferred to a general hospital where enucleation was done on the ninth day because of two diopters of optic edema in good eye. Two of the blast cases had little or no signs of external injury but had tears in the macula area with resulting 20/200 vision.

Wounds through whole thickness of lid require suturing in two layers. Those of the conjunctival layer being brought out in the conjunctival sac while those of the cutaneous layer are tied on the surface with a minimum of tension. The border of the lid must be repaired very accurately to avoid a disfiguring notch. After any crushing or lacerating wounds of the lids or orbit, a stimulating dose of tetanus antitoxin must be given. Today, all men in the armed forces are immunized at the training stations with tetanus toxoid and any man thus immunized must be given 1 cc of tetanus toxoid after suffering a crushing or lacerating injury. Sulfathiazole should be given in large doses by mouth and locally the wound should be sprinkled liberally with sulfanilamide powder which is not irritating to the conjunctiva or cornea.

After these blast injuries it is not uncommon to find one or both cornea studded with minute fragments of rock, sand, carbon or gunpowder. The larger ones should be removed. It is an almost impossible task to remove many of the finer particles. If atropine is employed and a 5 per cent sulfathiazole ointment in a white petrolatum base applied most of these particles will disappear in a day or two with little or no loss of vision.

Hysterical and malingering cases occupy an important and interesting place in army eye work. If the soldiers learn that eye conditions can be an easy escape route from unpleasant duties malingering may become popular. Many of the cases have been shown to be hysterical, or "a little careless with the truth." Several have proved to be out and out malingerers. One man was tried by courtmartial and sentenced to four months at hard labor and given a pay deduction of \$22.00 per month. One sergeant had previously a large iridectomy from a penetrating wound several years before induction. He came in the day before the examination to

state he had a good opportunity for advanced rating and was very anxious for his vision to allow him to go overseas. The next day he was quite enthusiastic and repeated that he was very anxious to make the trip. Fundus examination was negative. At refraction he saw 20/20 in the normal eye, but could make out only the dark lines in the 20/400 line with the eye that had previously had the iridectomy performed. With both eyes open he read 20/40 (the vision in the normal eye had been occluded.) When the allegedly blind eye was covered he could not repeat any of the letters. Confronted with this he broke out in a cold, clammy sweat, became pale and almost went into shock. He confessed he did not want to go overseas because he was worried about his, and his mother's health. She had varicose veins. He was not given a courts-martial because it was thought he had learned a big lesson and it was better to let him go overseas and try to make a good soldier, rather than reduce his rank to a private, put him in prison for several months and completely break his morale.

There are many methods used to detect malingering. Those who claim equally defective vision in each eye will tax the ingenuity of any ophthalmologist. The easier ones claim poor vision in only one eye. One method of detection is to correct each eye as best possible — and then fog the normal eye with a \pm 2.00 lens in addition to his correction. Have him then read with both eyes open. If the patient closes his eyes and tries out each eye separately have him go out and wait another hour before examining him again. *Harlan's Test* — Have the examinee cover with his hand the allegedly blind eye. Place before the good eye a \pm 6.00 prism lens. This eye, if emmetropic, can now read fine print no farther than $6\frac{1}{2}$ inches. Hold a card of fine print close to the eyes — ask the examinee to uncover the poorer eye and then to read aloud. As he does, so slowly move the card farther than $6\frac{1}{2}$ inches away. If he still reads he is doing so with the allegedly blind eye.

Perhaps the most clever and most practical, is the American Optical malingering apparatus. With poloroid lenses on each eye (over the correction) — one at 90 degrees and the other at 180 degrees the slide which fits in the projecto — chart can be turned by a lever so that the examinee can see with both eyes — or each eye can be occluded separately. If the eyes have nearly equal vision it is very difficult for anyone to tell with which eye they are seeing. The level is placed so that the examinee can see with both eyes and he is shown that he can see with each eye. He is now asked to begin reading aloud in the 20/100 or 20/70 line. As he

reads the lever is turned so as to occlude the vision in the normal eye. If the vision is poor in the other eye he will stop reading immediately, but if the eye sees well he will continue to read 20/50, 20/40 or even 20/20. The alleged blind eye is now covered with the hand and the patient is shown that he read with the alleged blind eye because he cannot see anything with the normal eye. A confession can be had.

Enlisted and civilian personnel, if not well trained when assigned, can be very great help in a short time. Equipment and instruments are very adequate. Much good can be rendered to the soldiers and army eye work continues to be a very fascinating game.

DISCUSSION

DONALD L. MISHLER, M.D.

TULSA, OKLAHOMA

Major Sanger's paper was informative and very interesting. He has given us a clear concept of some of the problems in ophthalmology that are common in the military service, and an outline of the treatment in these conditions.

The difficulty of making an eye survey is fully appreciated by this speaker, as I have spent many hours examining inductees. Ma-

jor Sanger spoke of men, who with vision of 20/400, were able to see 20/40 to 20/20 with a plus or minus 0.25 sphere. Well, I have found at the induction center that the use of a trial frame alone with no lenses at all has a remarkable effect on visual acuity, especially among the negroes. Acute conditions and treatment of these appear to be similar to what we encounter in private practice.

I was somewhat surprised at the number of eye injuries which occur among the training of a soldier. However, this fits in with what I have observed at the induction station. I have become aware of the great number of eyes that are blind due to trauma, so it is easy to understand why there would be many accidents during maneuvers in as much as there are many men who have never been in the woods or around explosive before.

Land mines and booby-traps have turned out to be very effective in producing casualties to our soldiers, which is exactly what the enemy desires. Therefore, it is absolutely necessary that our soldiers are given training to protect themselves regardless of many eye injuries. C'est le guerre.

I do not envy a malingerer who is to be checked by the Major as I have no doubts but what he would be caught red-handed.

Tonsillectomy In Young Children With Allergy

G. C. MOORE, M.D.

PONCA CITY, OKLAHOMA

In defining young children with allergy in relation to the above caption, I have in mind children up to five or six years of age. Allergy is a very prevalent condition in this section of the country, and seems to be increasing in prevalence in relative proportion to the increased incidence of bottle fed babies and complicity of foods. I do not care to discuss allergy in all its manifestations or etiological aspects, as it is a specialty that is highly developed and one which has made great strides. Unfortunately, a very small percentage of allergic children receive advice or treatment from any allergist.

The functions of the tonsils and adenoids are so well known that I will not include them in this discussion. The auto-immunization, by germs developing toxins, and lymphocytic functions are well known and understood. Just why there is a hypertrophy of the lymphoid tissue in the throat in allergic chil-

dren though many not be so readily explained. I do not care to enumerate the well established indications for the routine removal of tonsils and adenoids, as I believe this, also, is well understood.

An allergic child usually arouses its parents interest by such symptoms as stuffiness in the nose, difficult nasal breathing, apparent head colds, often or almost continuous. They take the child to their physician, he looks in the throat, sees the tonsils are enlarged and advises their removal for the relief of the patient's symptoms. The parents consent, with the hope that the child's symptoms will be cleared up, only to find they are made worse and usually a sinusitis is added to the former complaints with lowered resistance. The parents may become discouraged in a few months and take the child to another physician. Often he finds what he thinks is a return of the tonsils and adenoids. The

first physician is usually criticized, and the child started over the same routine again for the removal of whatever lymphoid tissue that has grown back. The child may be carried through another very unpleasant procedure with similar results. Finally, his age, tolerance, and his knowledge gained by past experience, avoiding contacts, foods, etc., he gets along fairly well.

I do not believe that enlargement of the tonsils per se is sufficient reason for their removal, and Major Lee K. Emenhiser, M.C., says, "It should be emphasized that hypertrophy is by no means synonymous with diseased tonsils."

Hypertrophy of the lymphoid tissue in the throat, including the tonsils and adenoids, is one of the signs of allergy. Most of the obstruction to breathing, however, comes from changes in the nose, and not the throat. As every one knows, the mucosa in the nose in cases of allergy is of a whitish hue and the turbinates are swollen, soggy, and fill the vestibules on both sides of the nose. The removal of the tonsils and adenoids does not change this allergic condition, the breathing remains difficult after their removal, because of these allergic changes in the nose. As a matter of fact, it is remarkable to see children with tonsils so large that they meet in the center of the throat when the patient's mouth is opened, but as a rule the patient does not manifest any difficulty of breathing because of this hypertrophy.

If the tonsils are not definitely diseased they should not be removed in allergic children until six years of age. If the adenoids

obstruct the orifices of the eustachian tubes they can be removed any time. The operation should be repeated if obstruction recurs. The tonsils and adenoids should not be removed in early childhood unless they are chronically diseased or unless they are causing some systemic condition, as rheumatism, heart or kidney trouble. In allergic children it should be remembered it is better to err on the conservative side.

I'm not averse to removal of tonsils and adenoids in children and have at times advocated their removal in all children beyond the age when tonsils and adenoid function prophylactic measure. But, if possible, the allergic child should keep his tonsils longer than the non-allergic child.

The lymphatic glands react to infections in and around the throat in proportion to the kind and virulence of the infection, I have never quite understood the underlying cause for such prolific lymphoid tissue formation in the throat in allergic conditions. It is evidently a protective formation on the part of nature, but just how it reacts against allergins, except as a protective blanket, I do not know, nor have I read anywhere, the reasons for such changes.

I wish to place this subject before the profession, for the sake of good ethical medicine, and for the sake of unfortunate, allergic children, the plea that a decision to remove tonsils and adenoids be arrived at honestly, after careful study and close observation. The allergic child should be permitted to keep that barrier of protection nature has provided, for what it may be worth.

Cancer of the Rectum and Rectosigmoid*

RAYMOND L. MURDOCH, M.D.

OKLAHOMA CITY, OKLAHOMA

A summary of fifty consecutive radical resections of the rectum and rectosigmoid for malignancy with comments also on the features of the other cases coming up for differential diagnosis and the complicating conditions which prevented their having the radical resection, but for which complicating conditions they would have been in the consecutive list.

The fifty consecutive resections were done by six different types of operation selected according to the condition of the patient and the location and extent of the cancer. Respective types of operation and the number

of cases falling under each one as follows:

One-stage combined abdomino-perineal resections with abdominal colostomy (Miles)	19
One-stage combined abdomino-coccygeal, sliding colon to (1) anus or (2) to perineal colostomy outlet (Babcock)	14
One-stage posterior resections or amputation, operating only from below	4
Extensive mobilizations of rectum and Mikulicz (abdominal) removals of rectosigmoid malignancy, with subsequent closure of the Mikulicz	2

*Professor Clinical Surgery, University of Oklahoma Medical School.

Two-stage with single barrel abdominal colostomy and subsequent removal of ALL gut distal to it	7
Loop colostomies followed by posterior resection, leaving the blind end of the sigmoid. This two-stage operation is a compromise for poor risk patients but ultimately less satisfactory than the other operations	4
Total consecutive resections	50

There were two hospital deaths both being caused by pneumonia, eight and nine days respectively, postoperatively. There were 46 consecutive resections without a mortality. Thirty-nine of the fifty were one-stage removals. There were 28 male, 22 female; there were 47 caucasian, 3 negro. Four had malignant liver involvement at the time of the resection which nevertheless was done for relief of pain, tenesmus and hemorrhage; all were operative recoveries, three returning to their previous occupations for periods up to one and a half years before the inevitable malignancy death.

The oldest patient subjected to resection was 78 years of age and had slight auricular fibrillation during some of his hospital stay but has not been incapacitated for several years subsequently. The youngest patient was 22 years of age and had been sent in for deep x-ray therapy as inoperable after exploratory laparotomy elsewhere. She gained 60 pounds after I resected her large growth and contiguous tissue; despite the almost hopeless prognosis of malignancy in the very young it was one and a half years before she had any recurrent complaints in the pelvis. Within six months after that she succumbed to recurrent colloid type of adenocarcinoma. The average age of the series was 51.8 years.

COMPLICATING CONDITIONS

One or more of the following complications existed in each of the fifty patients reported, namely:

- Anemia (majority of the cases)
- Auricular fibrillation, slight, due to senile myocarditis
- Large fibroid uterus
- Hernia, inguinal, reducible
- Appendicitis
- Gallstone, apparently solitary, in the gallbladder — two cases (They had uneventful resection convalescence)
- Polyps, one to numerous, in the resected bowel separate from the malignancy — several cases
- Lung markings by x-ray diagnosed chronic (2 months persistent) unresolved pneumonia
- Trichomonas hominis, intestinal
- Entamoeba histolytica, intestinal
- Syphilis, old, with slightly positive Wassermann — two cases

Syphilis, probably cured, negative Wassermann.

Malaria, tertiary (had chills and positive microscopic after resection; relieved by atabrine)

Liver grossly involved by malignancy — four cases

Recto-vaginal septum and perineum malignantly involved — several cases.

COMPLICATIONS AT THE TIME OF RESECTION

Perforation of the bowel was encountered or made in a number of cases during removal.

The hemostat once was pulled off of the inferior mesenteric artery before it was ligated, but same was retrieved and the postoperative course was satisfactory.

Considerable bleeding occurred deep in the pelvis in several cases. Blood transfusion is given routinely the day of operation.

COMPLICATIONS AFTER RESECTION

Postoperative complications included acute bronchitis, pleurisy, pneumonia and ileus as well as the following:

Parotitis, acute, suppurative, one case, was first detected on the fourth postoperative day, was given minimal doses of x-ray with progressive decline of fever but had to have a small area of fluctuation incised and pus drained, subsequently. The wound healed and the patient left the hospital in good condition. This complication arose in spite of our routine administration of several drops of lemon juice every few hours from time of operation.

Excess of colostomy, both abdominal and perineal, has been corrected several times either by clamping parts with hemostat left in place several days or by touching with the cautery.

Marked left abdominal wall relaxation occurred around and more especially below the colostomy in one of the two-stage resections. (Similar sagging has occurred in a descending colon resection around the area of the secondarily closed Mikulicz). Nearly six months elapsed after the second operation in each instance before the abnormal condition was much noticed.

Retraction and near occlusion of the left rectus colostomy occurred in one case which had to have wide enmasse removal of peritoneum contiguous to 24 inches of terminal bowel, and sliding of a double pedicled flap of peritoneum from the bladder sides to get the new pelvic floor constructed. This complication one month postoperative was successfully and entirely corrected by abdominal operation making a new deep mobilization and delivery of the functioning bowel with the superficial body wall tissue left attached on one side temporarily for circulation.

RADIATION

Therapeutic radiation has been given preoperatively in only a small proportion of the cases. The time required may cause delay associated with extension of the malignancy. In a number of cases finally coming to laparotomy we have found peritoneal metastasis prohibiting radical resection. One is unable to say, of course, just when the extension started. Regrettable delays have occurred also from causes other than preoperative radiation. Incidentally, a thoroughly radiated case several inches in diameter which we later resected, showed grossly only scarring at the site on the mucous membrane but the mesorectum starting immediately under the surface showed a large area of hard cancerous tissue. This may be the situation in some of the cases that occasionally are reported cured by the fulguration of rectal cancer soon after the fulguration.

Postoperative radiation is given when requested by those concerned and also if there is subsequent pelvic pain.

OPERABILITY

We do not feel that our field of operability has been too limited. Surgery, in addition to the resection, has been necessary in advanced cases as follows: resection and anastomosis of adhered small intestine; appendectomy and salpingo-oophorectomy; hysterectomy; double seminal vesiculectomy with shaving off of posterior prostate and urethra, the latter being sutured in two cases and healing in one; removal of involved portion of posterior vagina in several cases, and this plus all the perineum and half the labia in one case. Cases of this sort may be expected to have recurrences even though they survive enmasse resection.

Occurring concurrently with these fifty radical sections, only ten hospital-admitted rectal malignancies failed to get resection: one refused operation; exploration showed peritoneal metastases in one; one died the day before scheduled fulguration; another died twelve days after being dismissed as hopeless for any procedure; three died in the hospital following colostomy (interesting features of these cases are discussed under "Complications in Other Patients Given Only Colostomy"); and three did not improve sufficiently after colostomy to warrant resection. One of these latter seemed peculiarly resistant to measures to increase hemoglobin. It could scarcely be gotten to 50 per cent and would fall back to 40 and 30 per cent. Pregnancy was finally quite evident as an aggravating associated condition.

The above figures indicate an operability of about 75 or 80 per cent for this group of fifty resections. Resected cases average about a 50 per cent five year survival rate.

COMPLICATING CONDITIONS IN THE OTHER
PATIENTS GIVEN ONLY COLOSTOMY
(DONE CONCURRENTLY WITH
THE FIFTY RESECTIONS)

MALIGNANT RECTAL PERFORATION OR
PENETRATION

CASE 1

Mrs. D. M. 106655, Age 60 years. High rectal digital examination reveals fixed mass; abdomen is distended. X-ray shows malignant pathological fracture neck or right humerus with marked destruction of bone. Biopsy of the high rectal mass revealed scirrhous adenocarcinoma. Four weeks later through a left McBurney incision under local anesthetic, a simple loop sigmoidostomy was done. Pus was encountered at the left of the sigmoid, B. coli odor; drainage tube was placed. The colostomy was only partly opened after several days, making a small hole for gas escape. Death occurred in one week. Query: Did taking the biopsy have anything to do with abscess formation found subsequently? I think probably it did not.

CASE 2

Mrs. A. W., 102610, Age 49 years. Rectal digital examination discovered a mass diminishing the lumen of rectum about five inches up and behind the cervix. This was continuous with induration in the posterior vaginal vault accompanied by a fistula discharging fecal matter into vagina. Biopsy from the high rectal lesion was reported carcinoma, probably epidermoid. Single barrel colostomy was done without exploration on account of the poor condition of the patient. Excoriation of the abdominal wall occurred similar to that already observed in the vulvae and the exhausted patient expired 34 days later. Autopsy refused.

EVISCERATION

CASE 3

Mr. J. C. Age 61 years. Chief complaint: Constant uncontrolled leakage from the bowel, much weight loss and weakness, and some mental deterioration. Digital examination revealed a deeply eroded extensive induration of most of the ampulla of rectum, a biopsy showed adenocarcinoma. Single barrel colostomy was done through short left rectus incision under spinal anesthetic, closure in layers. Sometime during the fifth postoperative night the colostomized colon was compressed downward and one and one-half feet of small intestine extruded on the up side of the colon adjacent to it through a channel no larger than one's finger. There was no hemorrhage but serous fluid soaked the dressings and bed clothes. Though the intestine were sprinkled with sulfanilamide and replacing under short ether anesthesia twelve hours after evisceration occurred, the patient died the following night.

PREGNANCY

This case has been detailed in the text above under the section headed "Operability." Pregnancy seriously complicates the management of a cancer case, especially when the pelvis is involved.

SUMMARY

Six different resection operations and some minor variations are detailed in fifty consecutive resections of the rectum and rectosigmoid for malignancy. There were two hospital deaths. An overlapping fifty consecutive resections of the left colon and rectum resulted in one hospital death.

Twenty of the 50 rectal resections have no abdominal colostomy and vary from fairly good sphincter control to the usual colostomy function, in these cases brought out through the perineum. The blurb of gas is less annoying in the perineal location, even when the anus and sphincters have been widely removed. No painful benign strictures have resulted. But those perineal colostomies in which the stub has been trimmed or brought down flush with the skin level have a small diameter outlet making enemas necessary. Immediately inside the integument the bowel cavity bulges. One case that had also vaginal invasion included in the resection has local malignant recurrence and a longer terminal small outlet that is constricted and painful.

Checking the abdomino-coccygeal one-stage resections with Perineal outlet, favored by Dr. Babcock, (the second group listed in this paper), the first four of them have been done more than five years; three are apparently cured then, six and five years respectively after resection. Two held over a quart enema without leaking. One of the cases succumbed to recurrence nine months post-operatively. Conclusions cannot be drawn from the first four cases. The operation is applicable only in selected cases. The survival rate seems to compare well with that of the average of rectal resection operations in subsequent years and amounts to about 50 per cent survival after five years.

CONCLUSIONS

A careful digital rectal examination with the patient recumbent should be a part of every general physical examination. This should be supplemented in most cases by examination with the electrically illuminated proctosigmoidoscope. If there are symptoms possibly referable to the large bowel then its extent above the reach of the proctosigmoidoscope should be fluoroscoped and filmed during and after the gradual instillation of an opaque enema.

Improvements in the preoperative preparation, supportive measures, anesthesia, and individual selection of operation, are giving

better results in cancer surgery of the lower bowel. Careful consideration of the condition of the patient, the location, extent, and several characteristics of his terminal bowel cancer, will enable one to choose the operation which is best for the individual case.

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Book Reviews

PRACTICAL MALARIAL CONTROL. Carl E. M. Gunther, M.D., B.S., D.T.M. (Sydney) Philosophical Library, 15 E. 40th Street, New York. 1944. 91 pages.

The author Carl E. M. Gunther, M.D., B.S., D.T.M. (Sydney) is a practical and distinguished entomologist, as well as a clinician, versed in tropical diseases. He recites first handed information of this ubiquitous and devastating disease, both from mortality (4,000,000 per annum) and morbidity, to say nothing of its vast economic implications.

This book is a vade mecum, given out to our medical and public health officers while in service at home and the far flung war forces.

There are still many controversial questions about malaria, but time and observation is eliminating many obscure points, so his experience must be accorded much merit. Natural immunity to malaria is something not fully appreciated, and quinine should not be given as a prophylactic to those for fear of interference with their tolerance. Prophylactic quinine given must imply prophylaxis against attacks of malaria rather than against acquiring infection. Non-immunes in polluted districts are certainly dangerous to the immunes when bilitated together. Anopheles, the vector flies and feeds in "half lights," i.e. dusk and dawn.

The author says "he has found quinine so effective and so safe for general use in the field, that I have not thought it necessary to look further." Atabrine is more expensive and more toxic. Hypochlorhydria patients will not absorb enough quinine to do them any good. He claims quinine is absorbed only in the stomach and is an acid solution. The reticulo-endothelial system harbors parasites in chronic malaria that quinine cannot kill. So, once malaria, always malaria.—L.A.R.

MANUAL OF MILITARY NEUROPSYCHIATRY.

Edited by Hary C. Solomon, M.D. and Paul I. Yakovlev, M.D. W. B. Saunders Company. Philadelphia and London. 1944. 764 pages.

This manual was elaborated on the basis of one privately published by the former superintendent of the Metropolitan State Hospital, Waltham, Massachusetts, Roy D. Halloran. This was the "Collected Lectures" of

the "Seventh Postgraduate Seminar in Neurology and Psychiatry, including a Review Course in Military Neuropsychiatry," held at the Metropolitan State Hospital in 1941-42. The postgraduate seminars had been given each year for those who wished to take the examination of the American Board of Psychiatry and Neurology. Those of us who have taken these seminars remember Dr. Solomon as an able teacher of psychiatry and Dr. Yakolev as one of the few who can teach neuroanatomy and neurology in a way that is entertaining and easily understood. Furthermore we recall the whole course as one of the most clear, simple and practical in our experiences. One is not surprised therefore to find in this manual a series of papers by forty-five collaborators which cover the field of neurology and psychiatry in the same clear and practical manner. This makes it of great value to the general practitioner as well as the specialist.

The first three of six sections, covering 127 pages, is devoted to the administrative aspects of military psychiatry. The fourth section, with 341 pages devoted to "Clinical Entities," is the portion of the book with the greatest value to the general practitioner. This covers virtually the whole field of neurology and psychiatry in a succinct fashion. Sample chapter headings are "Psychoneurosis and Psychosomatic Disorders," "Alcohol and Alcoholism," "Sexual Deviates," "Principal Psychoses," "Common Diseases of the Nervous System," "Peripheral Nerve Injuries," "Spinal Cord Injuries," and "Post Traumatic Syndromes."

Section five has to do with prevention and treatment of neuroses and psychoses with emphasis on the military aspects of the problem.

The final section "Special Topics" is devoted to the special problems met in the tropics, in convoys and torpedo casualties, and in flying and ends with discussion on spinal fluid and electroencephalographic examinations.

The book is recommended to all physicians as a quick reference book when meeting unfamiliar neuropsychiatric disorders.—*Hugh M. Galbraith, M.D.*

DOCTORS AT WAR. Edited by Morris Fishbein, M.D., Editor of J.A.M.A. and Hygeia Health Magazine. Chief Editor of War Medicine, Chairman of the Committee on Information of the Division of Medical Sciences of the National Research Councils. Illustrated with 82 photographs, charts and diagrams. E. P. Dutton and Company. 1945.

Medical histories of the Second World War are in the making, under the auspices of the Division of Medical Sciences of the National Research Council, as it contemplates a fourteen volume edition.

The editor of this 418 page book has called together sixteen collaborators, each one the head of their respective divisions of this momentous problem of life and health thrown upon them by our entering this global war. They are presenting the activities of the Procurement and Assignment, Surgeon Generals of the Army and Navy, Public Health, Red Cross, Veterans Administration, Air Forces, etc., etc., and what they have done to enhance the efficiency and power of medicine in its various phases.

No better evidence of the fruition of their efforts can be given than to quote the statistics of General Hugh Morgan on war medicine.

	War No. 1	War No. 2
Death rate in wounded	8.1%	3.2%
Meningitis mortality	38.0%	4.0%
Pneumonia mortality	28.0%	0.7%
Dysentery	1.6%	.05%
Annual death rate per 1,000 for all diseases in the army excluding surgical conditions are 15.6% in the first war and 0.6% in the second war.		

Those who wish to have an insight into this vast and complicated undertaking and want to hear first hand from the men who make the wheels go round, should read this book. It is written for both the medical profession and the laity and should clarify to many

parents what protection is thrown around our war forces. Heretofore most all armies have lost more personnel by disease than by enemy bullets. Napoleon's Russian campaign was thwarted more by disease (typhus et al) than by the Russian arms. Accounts from active service in Guadalcanal and Tarawa as well as fronts mingled with science and feats of heroism were not dreamed of up until the medical department of the army was given authority and dignity to carry our sanitary prophylactics and up to date civilian practice on our fighting line.

The author starts out by saying "Military philosophers say there could never be wars if there were no doctors." Someone has said "The wise physician skilled our wounds to heal, Are worth more than an army to the common weal."—*Lea A. Riely, M.D.*

Medical School Notes

The passing of the Twentieth Legislature marked the passing of certain measures which will indelibly affect the School of Medicine of the University of Oklahoma. Of significant importance to the medical profession and the State as a whole, was the passing of Appropriations Bill 101, which appropriated \$1,432,503.10 — "For construction of buildings, improvements and purchase of equipment for and at the School of Medicine of the University of Oklahoma and Hospitals, all being divisions and part of the University of Oklahoma and being also several of the institutions comprising the Oklahoma State System of Higher Education." In his report to the Appropriations Committee, Dean Lowry recommended that the needs of the School of Medicine be portioned in the following manner: \$375,00 for the School of Nursing, \$175,000 for the Isolation Wing, \$75,000 for the Outpatient Department, \$400,000 for additional hospital beds, \$225,000 for an annex to the Medical School, and \$100,000 for remodeling, heating, power plant, laundry and shops. Whether or not the above recommendations will be followed to the letter depends entirely upon the priority of the needs or whether or not new and urgent needs take priority over any of the above list, for in essence, there is no stipulation of prorations in the bill, which was passed in the amount of \$1,432,503.10.

House Bill 463 is a bill legally naming The School of Medicine of the University of Oklahoma, which shall be administered under "rules and regulations made by the Dean and approved by the Board of Regents provided that said School of Medicine or said Board shall not prohibit the use of the hospital to any physician and surgeon licensed to practice in this state by the Board of Medical Examiners, thereof, and who is not connected with the School of Medicine."

House Bill 200 changes the Confederate Home at Ardmore to the Southern Oklahoma Hospital, to be under the supervision of the University of Oklahoma. A \$250,000 appropriation will be used to match funds of a like amount from the citizens of Ardmore, which will likely be matched in like amount from federal funds. This will possibly mean a One Million Dollar institution for southern Oklahoma, for the cure of chronic, tuberculosis, and general patients.

Dr. George N. Barry has resigned as Medical Director of the University Hospital and the Oklahoma Hospital for Crippled Children in order to be available for a commission in the United States Navy. Dr. Barry has served on the staff of the University Hospital since 1937, and has served as Medical Director since 1941. He has been granted a leave of absence from the faculty as Assistant Professor of Clinical Medicine.

Mr. Paul H. Fesler has been appointed Administrator of Hospitals for the University Hospital and Oklahoma Hospital for Crippled Children, effective June 15, 1945. Mr. Fesler is a charter fellow of the American College

of Hospital Administrators, and is past president of the American Hospital Association. He is a member of the Council on Planning and Management of the American Hospital Association and was Chairman of the Teaching Section of the American Hospital Association for a number of years. He was formerly Superintendent of the University Hospital and Hospital for Crippled Children, and is largely responsible for the present buildings. He was later Superintendent of the University of Minnesota Hospital, and also Superintendent of the Wesley Memorial Hospital of Chicago, a teaching hospital for Northwestern University Medical School. For the past year, he has served as Executive Secretary of the Oklahoma State Medical Association.

Recent acquisitions of the Library of the School of Medicine of the University of Oklahoma: Abt, I. E., Baby doctor. 1944; Adams, R. C., Intravenous anesthesia. 1944; Alexander, E. L., Operating room technique. 1943; American Medical Association, Handbook of nutrition, 1943.

Babcock, W. W., Principles and practice of surgery. 1944; Babkin, B. P., Secretary mechanism of the digestive glands. 1944; Bailey, Hamilton, Demonstrations of physical signs in clinical surgery, 9th ed. 1944; Bakwin, R. M., and Bakwin, Harry, Psychologic care during infancy and childhood. 1942; Ballenger, H. C., Manual of otology, rhinology and laryngology, 2ed., 1943; Barton, Betsey, And now to live again. 1944; Bell, E. T., Textbook of pathology. 5th ed., 1944; Bellows, J. G., Cataract and anomalies of the lens. 1944; Biddle, H. C., Chemistry in health and disease. 1940; Bierman, William, Physical medicine in general practice. 1944; Blackfan, K. D., and Diamond, L. K., Atlas of the blood in children. 1944; Bray, W. E., Synopsis of clinical laboratory methods, 3d ed., 1944; Bremer, J. L., Textbook of histology, 6th ed., of "Lewis and Stohr", 1944; Brill, A. A., Freud's contribution to psychiatry. 1944; Brumley, O. V., Textbook of the diseases of the small domes-

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The Journal of the International College of Surgeons had been added to the list of periodicals received as a gift of Dr. C. E. Clymer.

Life

Life! we've been long together,
Through pleasant and through cloudy weather;
'Tis hard to part when friends are dear;
Perhaps 'twill cost a sign, a tear;
Then steal away, give little warning,
Choose thine own time;
Say not Good-night, but in some brighter clime
Bid me Good-morning!

—Anna Letitia Barbauld, *A Physician's Anthology of English and American Poetry*, p. 330.

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1. Am. J. Dis. Child. 54: 1227, 1937.



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THE PRESIDENT'S PAGE

The four point program for the Oklahoma State Medical Association adopted by the Council and House of Delegates is in operation in most of the districts in the state. There is a lot to be done in an educational way regarding the program for the different heads; namely, the educational program to the public, which is number 1; the post-graduate program to the doctors, number 2; the post war planning for the returning servicemen and the doctors who stayed home and did their part, number 3; and number 4, the cooperation of the State Association with the county unit wherein we request that each county meeting have a speaker from the Speakers Bureau of the State Association to bring a message of the activities of the State Association or a scientific message on any subject that the society might enjoy hearing.

The Executive Office will be glad to give you a list of the speakers whose responsibility it is to be on call to speak to each county any time during the year the county secretary makes the request. This also applies to the Board of Health which has an interesting message to bring you regarding the health of our state; the Cancer Committees will give you interesting and inspirational speakers on the cancer program and cancer control. The Tuberculosis Society through the tuberculosis program will likewise give you speakers; the Maternity Speakers Bureau, headed by Dr. Edward Smith of Oklahoma City, has a very interesting message to bring on the maternity conditions in the state. You have all heard this man speak and know of his ability.

There are speakers that will give you definite and detailed information on the Blue Cross and the Physicians Service. Dr. John Burton, Dr. Jimmie Stevenson, or Mr. Helland will arrange for a speaker at any of the county meetings. The Commissioner of Health will arrange a very interesting and inspirational program on the health program that would be well worth any evening's meeting in a county society.

The program for this month's activities will be: Muskogee, June 7, 2:00 P.M.; Supply, June 8, 6:30 P.M.; Bristow, June 12, time of day not set; Enid, June 13, 2:00 P.M.; Hobart, June 19, 7:00 P.M., lay and doctor's program; Duncan, June 25; Durant, June 26, 7:00 P.M. also 9:30 A.M. June 27 at the college; Hugo, June 27, 7:00 P.M.; McAlester, June 28, 7:00 P.M.



President.

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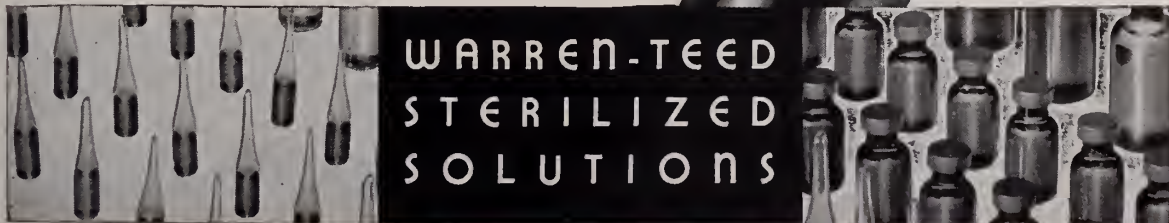
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EDITORIALS

THE UBIQUITOUS WAGNER BILL

On Memorial Day the Council of the Oklahoma State Medical Association met at the Association office in Oklahoma City. Among other things considered was the Wagner Bill. Since it is still impossible to place flowers on the grave of this ever recurring threat against our democracy, the Council passed a resolution condemning the bill and recommending that the members of the State Association write to their representatives in Washington for the purpose of registering a strong protest against the same.

We have won the European War against our way of life, but not without total mobilization, the exercise of great effort and the sacrifice of 1,000,000 casualties. Briefly this is an example of what it takes to protect our liberties from foreign aggression.

The Wagner Bill, originating within our own ranks, threatens an encroachment upon our liberties which will not only usurp our freedom but in the long run pyramid casualties which war could never equal.

This movement to bring about the regimentation of medicine and enslave both patient and doctor must not be tolerated. We must go to war. To win abroad and lose at

home means only defeat in the end. Every doctor should see that the people in his own community understand the true meaning of regimented medicine and should see that they employ their influence against this unsavory sop for their souls.

The Council went on record as approving the work of the National Physicians Committee and recommended that the members of the Association become identified with this committee, and that they support it by making small contributions. In addition the Council recommended that each member of the State Association write to his representatives in Washington telling them that the people are being informed as to the meaning of this proposed legislation and requesting them to vote against the Wagner Bill in order that the people who vote for them may remain free.

It is time to mobilize all our forces; time to fight for the freedom of our people at home and for their sons and daughters over seas.

When you receive a letter from the executive secretary outlining a course of action, please act. If you are an amoeba with no thought of tomorrow, this appeal will leave

you unmoved. If you are a rational red-blooded meat-eating man, with a normal conception of your rightful place in a free country, you will write the letter. You will let the law makers know how you feel. Procrastination may bring the small voice of conscience to dog your days.

Be a man!

OUR DOCTORS CONTINUE TO SPEAK OUT

After commenting on special articles in a recent issue of the Oklahoma State Journal, Major Clifford M. Bassett, formerly of Cushing, Oklahoma, now in Italy, made the following significant statement in a letter received June 2.

Apropos the Wagner Bill, this statement seems worthy of editorial notice.

"We in the Medical Corps of the U. S. Army, have served the Armed Forces well and without complaint and the American Soldier has received the best care of any soldier of any nation in the war. This is a statement that will survive the most critical examination. In addition, no single department in the U. S. Army with the exception of the "sole" infantryman and medical aid men, have been able to reach the heights attained by the Medical Department with respect to service and sacrifice.

"In the interest of the civilian doctor who has so willingly served his country and in the interest of fair play which is so much a part of America, is it not possible to postpone our transition into regulated and state Medicine until all soldiers now away from home can return and express their opinions on this subject so vital to all?"

THE ART OF MEDICINE

The art of medicine is multifaceted. While it consists primarily in the ability to inspire confidence and the power to lead the patient psychologically, there are many avenues to this most desirable accomplishment. Among the varied channels leading to the inner sanctum of the patients mind is the art of impressing the patient with knowledge and abilities outside the realm of medicine. For this reason, the sacrifice of a cultural background in medical education, in order to shorten the course, is to be regretted.

It is helpful to the doctor if he can exhibit knowledge and understanding in the field of the patients' interests. This field may be farming, gardening, literature, art or the simple methods of getting on with the problems of the average conventional life.

As an example, a certain physician, calling on an intellectual patient with a special in-

terest in artistic glassware, noticed an unusual display of Lalique artistically arranged in a beautifully lighted window on a spacious stairway landing. Having an eye for beauty, he was impressed and wisely decided to look up Lalique. On his next visit his patient was so pleased and surprised that she completely forgot many of her psychological complaints, a boon to the physician. This was a smart thing to do but the physician who can be loquacious about Lalique without looking it up is smarter. For the country doctor it may be a mounted turkey wing, a basket of eggs or a shelf of canned fruit, even though Lalique awaits him at home.

THE FASCINATION OF MEDICINE AS A FREE ENTERPRISE

In the United States the romance of true pioneering is a thing of the past, but the spirit that persistently pushed our hardy pioneers beyond the border is stingingly alive and eager for new worlds to conquer. Daily, the more ambitious among us imitate the genuine pioneers by doing little things which smack of the heroic, without the initiative, sacrifices and hazards of true heroism.

Today medicine stands among the few circumscribed fields of human endeavor where the spirit of adventure and exploration may place before the devout a shining horizon with the challenging promise of unsolved mysteries and untold potential benefactions to humanity.

It is this fascinating horizon and this potentiality for good that prompts doctors and other pure scientists without thought of time expended or material reward, to follow the urge for accomplishment. Such an individual would spurn the "four freedoms." He holds a thousand freedoms in one — the liberty to pursue his God-given urge unopposed whether it leads to success or failure. Under the rule expressed by Robert Louis Stevenson, the outcome is unimportant since success is in the striving.

We submit this flaming question. Has a cold, impersonal government the right to strangle such a useful, aspiring, unselfish enterprise as medical science with the deadening grip of bureaucracy.

THE MEDICAL OUTLOOK

Fortunately for the people and the medical profession there may be a further reprieve for regimented medicine. The fourth term political success for the present administration does not assure easy sailing for all domestic issues. Congress is not in a mood to respect party lines consistently. Because of the close popular vote, politicians will hold a receptive ear for the voice of the people. The coalition of conservative Democrats and

Republicans can create an Anti-New Deal block which may be beneficial to medicine as a free enterprise. Let us hope that the New Deal's grandiose social security dream, including three billion for regimented medicine without touching the indigent, may fall among the controversial issues. It would be a pity to disturb Bismarck's sleep with our surpassing social security program. If he were awakened now, his chagrin caused by the overwhelming success of his American rival in the wholesale purchase of power would be augmented by the roar of battle on his own soil through the abuse of the coveted power he purchased by placing the common people under special obligation to the government.

Pasteur's Grave

No cypress-shadowed churchyard, nor the gloom
The dust of him, whose patience proved more wise
To save, than Death to slay. The busy loom
Glancing with silk, the teeming herd, the bloom
Of purpling vineyards, and the grateful eyes
Of souls reprieved at Death's most dread assize,
Shall make eternal gladness round his tomb.
Nor 'mid the dead should he be laid asleep
Who wagheth still with Death triumphant strife,
Who sowed the good that centuries shall reap,
And took its terror from the healer's knife;
Defender of the living, he shall keep
His slumber in the armory of life.

—Alfred Hayes. *A Physician's Anthology of English and American Poetry*, p. 323.

Osler the Ideal Physician

What made him, in a very real sense, the ideal physician, the essential humanist of modern medicine, was his wonderful genius for friendship toward all and sundry; and, consequent upon this trait, his large, cosmopolitan spirit, his power of composing disputes and differences, of making peace upon the high places, of bringing about "Peace, Unity, and Concord" among his professional colleagues. "Wherever Osler went," says one of his best pupils, "the charm of his personality brought men together; for the good in all men he saw, and as friends of Osler, all men met in peace."—F.H.G., *A Physician's Anthology of English and American Poetry*, p. viii.

Osler as Seen by Thayer

An eye whose magic wakes the hidden springs
Of slumbering fancy in the weary mind,
A tongue that dances with the ready word
That like an arrow seeks its chosen goal,
And piercing all the carriers of care,
Opens the way to warming rays of hope;
A presence like the freshening, quickening breeze
That, passing, sweeps the poisoned cloud aside.
An ear that 'mid the discords of the day
Catches the basic harmonies of life;
A heart whose alchemy transforms the dross
Of dull suspicion to the gold of love;
A spirit like the fragrance of some flower
That lingers round the spot that this has graced,
To tell us that although the rose be plucked
And spread its perfume throughout distant halls,
The vestige of its sweetness quickens still
The conscience of the precinct where it bloomed.

—William Sydney Thayer. *A Physician's Anthology of English and American Poetry*, pp. 204-205.

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Edit.: Ill. Med. J. 82:407 (Dec.) 1942

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MANUFACTURERS

ASSOCIATION ACTIVITIES

GOVERNOR KERR HONORED AT BANQUET

On May 30, Memorial Day, the Oklahoma State Medical Association honored Governor Robert S. Kerr at a banquet given in appreciation of his interest in the health of the people of the State. Also honored were the Legislators of the Twentieth Legislature, all of whom were helpful in the passage of the various health bills.

Five hundred guests were present in the Silver Glade Room of the Skirvin Tower Hotel, Oklahoma City. In addition to Governor and Mrs. Kerr, and the Legislators, officers of the Association, presidents of the County Societies, their wives and guests were present.



Hon. Robert S. Kerr, Dean Tom Lowry

Tom Lowry, M.D., Dean of the Medical School, acting as Toastmaster, opened the program after dinner was served, by expressing the appreciation of the Association to Governor Kerr and the Legislators for their part in the passage of the health bills. He then asked that the guests stand in a moment of silent tribute to those who had died in the service. Reverend John Abernathy, Pastor of the Crown Heights Methodist Church of Oklahoma City, gave the invocation.

Dr. C. R. Rountree, Oklahoma City, Past President of the Oklahoma State Medical Association spoke briefly on the past legislature and the future program of the Association.

Representative O. W. Starr, M.D., of Drumright, was called upon to speak and gave a short talk on the events which transpired in the House of Representatives. Dr. Starr then introduced the members of the House who were present.

In the absence of Representative Creekmore Wallace, Oklahoma City, Representative Fletcher Johnson, Bristow, spoke for the House of Representatives. Representative Johnson gave a brief speech concerning the medical profession and the legislation.

Senator Louis H. Ritzhaupt, of Guthrie, then gave a talk concerning the health legislation in the Senate and the efforts of the medical profession in the passage of health bills. Senator Ritzhaupt introduced the members of the Senate who were present.



*Paul H. Fesler; C. R. Rountree, M.D.; Tom Lowry, M.D.;
V. C. Tisdal, M.D.*

Speaking for the Senate, Senator M. O. Counts of McAlester, cited the benefits of the health program and expressed appreciation of the efforts of the medical profession.

Mr. Paul H. Fesler, Executive Secretary of the Oklahoma State Medical Association gave a short talk expressing appreciation of the interest shown by Governor Kerr and the Legislators in the health program.

Greetings from the Oklahoma University were extended by Dr. Geo. L. Cross, President. Dr. C. Q. Smith, President of Oklahoma City University also extended greetings and spoke briefly.

Dr. Grady Mathews, State Health Commissioner was introduced and said a few words.



Rep. O. W. Starr, M.D.; Grady Mathews, M.D.

Dr. V. C. Tisdal, President of the Oklahoma State Medical Association was introduced by Dr. Lowry, Toastmaster. Dr. Tisdal expressed the appreciation of the Association to Governor Kerr for his part in the passage of the health bills and his great interest in the health of the people. He also expressed the Association's thanks to the Legislators. Dr. Tisdal then introduced Governor Kerr and asked if he would say a few words.

Governor Kerr expressed his thanks for the honor bestowed upon him by the banquet given by the Association. He explained the health program as passed by the Legislature and expressed himself in full cooperation with the medical profession in their interests concerning the health problems of the State.

The banquet was well attended and was beautifully arranged. The dinner and arrangements were under the auspices of the Oklahoma County Medical Society and under the able direction of Mrs. Muriel Waller, Executive Secretary. Flowers were donated by the members of the Woman's Auxiliary and Mr. Frank Buttram.

DISTRICT COUNCILLOR MEETINGS GET UNDER WAY

The Four-Point Program as outlined by President V. C. Tisdal, has gotten under way during the month of June with the holding of District Councilor Meetings over the state. It is the purpose of the Delegation of Speakers to bring the program of the Association to the doctors.

On May 31 a meeting was held at Vinita, June 7 at Muskogee, June 8 at Supply. Future meetings include Bristow on June 12, Enid; June 13; Hobart, June 19; Duncan, June 25; Durant, June 26; Hugo, June 27; McAlester, June 28.

A Speakers Bureau consisting of some 60 physicians over the state have volunteered to appear at District Councilor meetings and County Society meetings in order that the messages included in the program can be brought to the doctors. Each meeting will be reported in detail.

DISTRICT COUNCILOR MEETING HELD AT VINITA

On May 31, a meeting was held at Vinita for the northern half of District 8. The afternoon medical meeting was held at the Eastern Oklahoma Hospital with ten present. Dr. J. G. Edwards, Councilor of District No. 8 opened the meeting with the plea that all of the physicians should join the National Physicians Committee in order that that organization may further the fight against the bills for regimented medicine.

Dr. V. C. Tisdal, President, outlined the Four-Point Program of the Association and explained that it was the aim of the Association to carry the program out over the state to better acquaint the doctors and the laity with the activities of the Association. He stated that a Speakers Bureau had been set up and speakers on all pertinent subjects were available, upon request, to County Societies for their meetings.

Mr. Paul Fesler, Executive Secretary of the Oklahoma State Medical Association told the doctors present about the legislation that was passed. Mr. Fesler outlined all health bills passed and explained how they benefited the health of the people of the state. He fully explained the State Board of Health Bill and told of its advantages.

Dr. James Stevenson of Tulsa was next called upon and gave the history of the Blue Cross Plan. This plan has been in operation in Oklahoma for five years and has been very successful. All surplus money is put back into the plan in benefits to the subscribers. Dr. Stevenson also explained the Oklahoma Physicians Service, the Prepaid Surgical and Obstetrical Care (another article on this subject will be found elsewhere in this issue).



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Dr. Tisdal outlined the Cancer Drive for funds now in progress and introduced Dr. Ralph McGill of Tulsa who spoke on the activities of the Cancer Committee of the Association. Dr. McGill gave the history of the American Cancer Society and told of the interest of the lay organizations in the drive to raise funds for the control of cancer. The goal set for the drive is \$150,000.00 and approximately \$87,000.00 of this amount has been raised. Fifty per cent of the money is to remain in Oklahoma and Dr. McGill discussed ideas for the expenditure of the funds. The first consideration will be that of education, another will be that of detection clinics.

Dr. Edwards, Councilor, then told the audience of the District Meeting scheduled for the southern half of District 8, to be held in Muskogee on June 7.

Dr. McMillan extends an invitation to the delegation from the Association for dinner at the Lion's Club to be held at the Vinita Hotel at 6:30, stating that Dr. H. H. Faust was in charge of the program. Dr. Faust asked that the delegation speak on the program for the Lion's Club dinner.

At 6:30 P.M., thirty members of the Lion's Club assembled for dinner at the Vinita Hotel. Dr. Faust turned the program over to Dr. Tisdal, who, in turn called on those who had spoken in the afternoon to give a brief resume of their speeches.

The evening meeting at the high school auditorium was intended for a lay meeting, however, due to late publicity, there were not many of the laity in attendance but several physicians from Vinita and surrounding towns were present. In addition to the speakers of the preceding program, Dr. Edward N. Smith, of Oklahoma City, spoke on the subject of Maternity Mortality. Dr. Smith outlined the activities of the Committee on Maternity and Infancy and went into detail to explain that 'dead women talk.' Through the use of questionnaires the records have been kept by the committee and show the causes for maternity mortality. Statistics show that 51 per cent of the deaths are preventable if the patient is educated in the necessity of consulting her physician.

MUSKOGEE DISTRICT COUNCILOR MEETING

On June 7, the District Councilor Meeting for the southern half of District No. 8 was held in Muskogee at the ranch of Dr. Charles Ed. White. Twenty doctors were present at the afternoon session which began at 3:00 P.M. Several members of the armed forces were present.

Dr. J. G. Edwards, Councilor for District 8, opened the meeting and stated that he wanted to urge membership to join National Physicians Committee in order to fight the Wagner Bill. He urged each County Society to stress this fact to its membership. Dr. Edwards then turned the meeting over to Dr. V. C. Tisdal, President of the Association.

Dr. Tisdal said that it was the purpose of the Association to take the program out over the state in order to call the attention of the people to the facts and to awaken the doctors to give information to the people. He then explained the Four-Point Program of the Association and cited the various activities of the Association. He told of the Speakers Bureau and urged the County Societies to ask for a speaker from the Bureau for their meetings.

Dr. Clinton Gallaher, Shawnee, was given the floor and spoke on the responsibility of the County Society to the Association. Dr. Gallaher stressed the fact that the Societies should encourage the activities of the younger men in the organization, thus making stronger societies and a stronger Association. He suggested many methods of progressing, such as a County Bulletin, study clubs, etc.

Dr. C. R. Rountree, Oklahoma City, was next called

upon to cite the Association's responsibility to the County Society. Dr. Rountree said that he thought it the duty of the Association to draw the members closer to the Association and to the American Medical Association and to subscribe to the Journal of the A.M.A. He explained that the Council and the House of Delegates were representative of the membership and it was each member's privilege to voice an opinion in the governing of the Association. The importance of the ensuing program was explained and Dr. Rountree stated that the membership would be advised by special bulletin as to the progression of the program.

Dr. Grady F. Mathews, Oklahoma City, representing the State Health Department then explained the functions of the Health Department and the extensive program carried on by them throughout the state. Dr. Mathews discussed the various appropriations in regard to public health and explained the E.M.I.C. program. The laboratory of the State Health Department was explained and Dr. Mathews urged the use of the laboratory by the physicians in the state.

Dr. L. C. Kuyrkendall, McAlester, was given the floor and spoke on Regimented Medicine. Dr. Kuyrkendall stated that the Wagner Murray Bill had been introduced into the Senate as a new Bill, S. 1050 but that it was the same as the original bill with a few changes, incorporating the Hill Burton Bill in an effort to get it through. The new bill states that the individual may select his own physician and own hospital, however, that physician and that hospital must be a member of the plan as outlined in the Bill. Dr. Kuyrkendall urged that the members read the Bill in the Journal of the A.M.A. and acquaint themselves with it. He stated that the doctors should put up more of a fight and not let this Bill pass.

Dr. James Stevenson, Tulsa, next spoke on the Blue Cross Plan and explained the Oklahoma Physicians Service, the Prepaid Surgical and Obstetrical Care Plan.

Dr. Finis Ewing, Muskogee, was called upon to speak on Public Policy. Dr. Ewing explained the need to the medical profession of a Public Policy Program. He cited how far the Association had come in the last ten years toward the realization of the necessity of this type of program. Dr. Ewing then reminded the members that their friends and patients should be educated along the line of medical legislation.

Dr. Ralph McGill, Tulsa, was called upon to explain the activities of the Cancer Committee. Dr. McGill told of the Cancer Drive and said that approximately \$87,000.00 had been raised, 50 per cent of which would stay in Oklahoma. He then explained the suggestions for the expenditure of the funds, i.e., public education, education to the schools and detection clinics.

Mr. Paul Fesler, Executive Secretary of the Association, read the list of the Health Bills as passed by the last Legislature (list elsewhere in this issue). He then explained the medical school appropriation and the tentative plans with regard to this.

Dr. Edward N. Smith, Oklahoma City, was then called upon to explain the activities of the Maternity and Infancy Committee. Dr. Smith explained the extensive work being done on gathering statistics regarding maternity mortality. Through questionnaires returned by attending physicians, it has been determined that 30 per cent of the maternity deaths are caused by toxemia, 21 per cent by abortion, 24 per cent by hemorrhage, 14 per cent by infection and 9.5 per cent by other causes. This shows that 51 per cent of the deaths are preventable by education to the patients. Dr. Smith stressed the importance of the survey in the reducing of the maternity death rate.

The meeting was closed by some remarks from Dr. D. Evelyn Miller, Secretary of the Muskogee County Society, regarding the infancy problem in war time.

After the meeting adjourned, those present and additional guests were served at a barbecue.



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MEETING AT SUPPLY WELL ATTENDED, ENTHUSIASTICALLY RECEIVED

The District Councilor Meeting for District No. 1 was held on June 8 at the Western Oklahoma Hospital at Supply, Dr. John L. Day, host. Seventy-five guests were present including physicians from all towns in the District, their wives and members of staff from surrounding hospitals and clinics. Also present were Senator E. P. Williams, Woodward and Representative C. F. Miles, Buffalo. At 6:30 P.M. dinner was served, during which the various members of the delegation from the State Association were introduced, also Senator Williams and Representative Miles.

After dinner, the group assembled in the auditorium of the Hospital for the evening program. Following a group of violin selections by Miss Betty Orriek, daughter of Dr. Orriek of Supply, Dr. O. E. Templin, Councilor of District 1, opened the meeting by expressing appreciation to the members who had brought the program from the State Association, and introduced Dr. V. C. Tisdal, President of the Association.

Dr. Tisdal first expressed thanks and appreciation to the House of Representatives and to the Senate for the program of health legislation passed in the last Legislature, and called upon Mr. Paul Fesler, Executive Secretary of the Association to explain the legislation. Mr. Fesler read the health bills, explaining each one and pointing out the benefits to the people and to the physicians. He expressed the appreciation of the Association to Governor Kerr in the passage of the health bills.

Dr. Grady Mathews, Oklahoma City, State Commissioner of Health, spoke on the State Board of Health and the doctor's responsibility. He expressed the belief that preventive medicine and curative medicine should go hand in hand. Dr. Mathews cited the many benefits offered by the Health Department to the people and to the medical profession.

Dr. Paul Champlin was next introduced and asked to explain the activities of the Cancer Committee. Regarding the past history of the American Cancer Society, Dr. Champlin told of the change in name from the American Society for the Control of Cancer and explained the workings of the Women's Field Army and the Cancer Committee of the State Association. He said that in the reorganization of the American Society the control had been given to the laymen interested in cancer. The objects of this group of laymen and of the American Cancer Society include the annual drive for funds, the creation of a medical board, the creation of a research council and a survey of the needs. He then explained the National, State and Rural drive for funds. Regarding the expenditure of money, Dr. Champlin stated that these would be the following considerations: education; research; support of organized tumor clinics; service to the inoperable.

Dr. Tisdal then explained the Four-Point Program and told the audience that it was the hope of the Association

that each Society would avail themselves of the opportunity to obtain a speaker for their meetings from the Speakers Bureau. He asked that each member join the National Physicians Committee by sending in a donation to that organization. The new Bill, S. 1050, should be carefully read by each member. It was explained that it was the Wagner Bill with a few changes and incorporated some of the Hill Burton Bill.

Dr. J. T. Bell, Oklahoma City, then spoke on the maternity mortality statistics and explained the causes of death and their prevention.

Mr. Fesler asked that the doctors write scientific papers and submit them to the Editorial Board of the Journal for publication. He also urged that each doctor read the Journal of the A.M.A. in regard to the new Bill, S. 1050.

A motion was made and seconded to express thanks and appreciation to the delegation from the State Association for the program and to Dr. Day and his staff for the dinner.

The meeting was exceedingly well planned and very well attended. All those in attendance were enthusiastic about the messages brought to them and expressed approval of the Program as outlined by the Association.

PREPAID SURGICAL AND OBSTETRICAL CARE PLAN NOW UNDER WAY

Through the cooperation of the Oklahoma State Medical Association, employed groups and associated groups may now avail themselves of prepaid Surgical and Obstetrical benefits on a community basis. The plan is in operation in five counties and plans are being made to extend it as soon as groups and County Societies ask for the plan. In order to have the plan in a county it is necessary for the County Society to obtain the wishes and approval of the community and then ask for the plan to be inaugurated in their particular county.

The object of Oklahoma Physicians Service is to ease the financial burden of sickness for the employee and the members of his family. The dues are as follows: employee only—\$0.75 per month; Employee and spouse (or child)—\$1.50 per month; Employee and spouse, and all unmarried children under 21 years of age—\$2.00 per month.

The Board of Trustees serves without remuneration. All surpluses that accumulate, in excess of reserves for contingencies, will be used to add other services. For further information regarding this plan write the Oklahoma Physician's Service, 10 E. 4th St. Bldg., Tulsa, 3, Oklahoma.

Pasteur's Grave

From the beginnings of civilization, physicians have excelled in serious studies.—F.H.G., *A Physician's Anthology of English and American Poetry*, p. xv.

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1. Compton, B. C.; Bieren, R. E.; Jones, E. G.; Inloes Jr, B. H.; Kardash, T., and Hundley, J. M.: Treatment of Gonococcal Vulvovaginitis, J.A.M.A. 127:6 (Jan. 6) 1945.

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SUMMARY OF HEALTH BILLS PASSED BY THE LEGISLATURE IN 1945

The following bills affecting public health were introduced in the Legislature, passed, and signed by the Governor.

House Bill No. 7—Pre-marital. Provides for examination for syphilis prior to the issuance of a marriage license. Requires serologic tests for syphilis performed in approved laboratory.

Senate Bill No. 54—Defining venereal diseases as communicable and providing for quarantine and reports by physicians to health department.

House Bill No. 77—Creating a nine member State Board of Health. Members to be appointed by the Governor — one from each Congressional District and one from the State at large. Five must be members of the State Medical Association.

Senate Bill No. 153—Providing for schools, boards of education, cities and towns to join with the county in creating and financing a County Health Department.

House Bill No. 172—Providing for the State Health Department to regulate, inspect, and license frozen food lockers, and to make certain rules and regulations for their operation.

Senate Bill No. 236—Repealing certain statutes and clarifying others relating to vital statistics. Registration of a stillborn child. Birth certificates shall not state legitimacy of child.

House Bill No. 303—Permitting the State Health Commissioner to accept Federal grants, personnel, and equipment from the Federal Government.

House Bill No. 367—Pre-natal. Provides that all pregnant women shall have a serological blood test for syphilis, and defining the duties of the attending physician.

House Bill No. 432—Providing for the inspection and labeling of mattresses and other types of bedding, and the issuance of permits to persons dealing in mattresses and other types of bedding.

House Bill No. 468—Making it the responsibility of the State Health Department to inspect, regulate, and license hospitals, sanatoria, and nursing homes.

House Bill No. 476—Provides for the Commissioner of Health to direct a survey of existing hospital facilities, and also provides for an advisory council.

House Bill No. 477—Appropriates \$141,000.00 for the fiscal year ending June 30, 1946, and \$231,000.00 for the fiscal year ending June 30, 1947, for the establishment and maintenance of county health departments. In order for a county to share in the State appropriations they must meet the requirements set forth in this act.

House Bill No. 478—Provides for a state-wide hospital plan. Creating an advisory council to vitalize the provisions of this act. Making provisions for sharing in Federal grants for the construction of hospitals in the State.

ConventionMrs. C. P. Bonduraud, Oklahoma City
War ParticipationMrs. Neil Woodward, Oklahoma City
PrintingMrs. James Steveuson, Tulsa

The Executive Board of the Woman's Auxiliary to the Oklahoma State Medical Association met in Oklahoma City on April 22nd, in a one-day session in place of the annual convention of the organization which could not be held this year due to war-time restrictions. In attendance were representatives from Ada, Shawnee, Tulsa, Norman and Oklahoma City. Mrs. C. E. Northcutt, Ponca City and Mrs. Finis W. Ewing, Muskogee, were guests. Mrs. Ollie McBride represented Ada, Mrs. C. C. Young, Mrs. Clinton F. Gallaher, and Mrs. Charles W. Haygood, Shawnee, Mrs. Felix T. Gastineau, Norman, Mrs. J. W. Rogers, Mrs. Carl Hotz, Mrs. Walter S. Larrabee and Mrs. Frank L. Flack, Tulsa and Mrs. Walker Morledge, Mrs. William E. Eastland, Mrs. Maxey Cooper, Mrs. Gerald Rogers, Mrs. John P. Wolff and Mrs. C. R. Rountree, Oklahoma City.

Committee Meetings were held on the mezzanine floor of the Hotel Skirvin during the morning. Mrs. William E. Eastland, Hospitality Chairman, for the Oklahoma County Auxiliary, had arranged for a luncheon which was served at 1:00 P.M. in the Oklahoma City and Country Club. The regular session of the Executive Board was then called to order by the president, Mrs. Clarence C. Young, of Shawnee. The annual reports of the County Presidents were not read but were filed with the secretary and were to be published in the Oklahoma State Medical Journal. Cancer Control was discussed. It was decided to continue the purchase of war bonds with funds from the Medical Student Loan Fund. With the purchase of this year's bond, the Auxiliary now has \$1,000.00 in bonds.

We are happy to announce that Murray County will be added to our County organizations this year. Her members will be a part of the Poutotoc County Auxiliary. The Poutotoc-Murray group will have members from Ada, Sulphur and Stonewall.

It was with much sorrow that the president, Mrs. Young, reported the death of two members during the past year. They were Mrs. Edna Gilbert, widow of Dr. J. B. Gilbert, and Mrs. Louella Walker, wife of Dr. William A. Walker, both from Tulsa. Mrs. Gilbert died December 31, 1944 and Mrs. Walker, July 30th, 1944.

Since the work of the state and county units is directed to a large extent by the Woman's Auxiliary to the American Medical Association, definite plans for the coming year will not be made until later when the new national officers will be installed. The Executive Board will also confer with the State Advisory Council, composed of doctors in the State Medical Association, before sponsoring any new projects. The election of officers was held. Those officer's names appear on this page. Mrs. J. W. Rogers, Tulsa, announced her Committee Chairmen for the year.

Woman's Auxiliary

OFFICERS 1945-1946

PresidentMrs. J. W. Rogers, Tulsa
President-ElectMrs. Ollie McBride, Ada
Vice PresidentMrs. Charles Rayburn, Norman
SecretaryMrs. Walter S. Larrabee, Tulsa
TreasurerMrs. Frank J. Nelson, Tulsa
HistorianMrs. Walker Morledge, Oklahoma City
ParliamentarianMrs. Claruce C. Young, Shawnee

COMMITTEE CHAIRMEN

Public RelationsMrs. Floyd Kellar, Oklahoma City
ProgramMrs. Clinton F. Gallaher, Shawnee
HygieneMrs. Ollie McBride, Ada
Press and PublicityMrs. Frank L. Flack, Tulsa
LegislationMrs. Gregory Stanbro, Oklahoma City

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PILOT'S CODE

In his column National Affairs, David Lawrence writes:

Broadcasts from Japan intimate that punishment has been meted out to an American flyer who, the Japanese say, came with the Doolittle raid over Tokyo. . . .

From the friends of the flyer an interesting memorandum has been obtained, which was written about the time he took up aviation in 1940, after he had attended the University of South Carolina for two years. . . .

Under the heading, "My Future," the flyer set down his thoughts as follows:

"The time has come to decide what rules I am going to set myself for daily conduct. My aim is decided—I am going into some branch of aviation. I have only to apply myself daily toward this end to achieve it. First I must enumerate my weaknesses and seek to eliminate them. Then I must seek to develop the qualities I need for this type of work. It's going to be hard, but it's to only way. Work with a purpose is the only practical means of achieving an end.

First, what are my weaknesses?

1. Lack of thoughtfulness and application.
2. Lack of purpose.
3. Softness in driving myself.
4. Lack of constant diligence.
5. Lack of seriousness of purpose — sober thought.
6. Scatter-brained dashing here and there and not getting anything done — spur-of-the-moment stuff.
7. Letting situations confuse the truth in my mind.
8. Lack of self-confidence.
9. Letting people influence my decisions too much. I must weigh my decisions — then act.
10. Keep my mind always clean — allow no evil thoughts to destroy me. My mind is my very own, to think and use just as I do my arm. It was given me by the Creator to use as I see fit, but to think wrong is to do wrong.
11. Concentrate! Choose the task to be done, and do it to the best of my energy and ability.
12. Fear not for the future — build on each day as though the future for me is a certainty. If I die tomorrow, that is too bad, but I will have done today's work!
13. Never be discouraged over anything. Turn failure into success."

CAPTAIN JOHN FLORENCE, Cushing, writes, in part, from Germany and Austria. "I am glad to know about the new construction work at the University Hospitals. Hope I can be back there again someday soon. I will need to go to school again after coming out of the Army.

"The war news looks better every day. We are really getting to see Europe, so my time has not been wasted. I am more convinced than ever that there is no place like the good old U.S.A. and I am ready to come home.

"... I received my promotion so now it is 'Capt.' I had a chance to see Hitler's home, or maybe I should say what is left of it for it was badly bombed. However, I got a few bottles of his best champagne."

LT. RAY U. NORTHRIP, Oklahoma City, is with the Navy and was in Okinawa when we received his last letter. He arrived there the day after the initial landing. He states that all in that theater were shocked at the untimely death of Ernie Pyle.

CAPTAIN JAMES T. McINNIS, Oklahoma City, is now serving in India. He writes that the monsoon will

soon begin in Assam and a "wet time will be had by all."

We received an interesting letter from COLONEL FENTON A. SANGER, Oklahoma City and quote it in part:

"We are somewhere in Germany and have been for some time, trying to keep up with the Army, which is some job as this has turned into another rat race. We are very busy, over 50 per cent of our cases have been operated. My chief nurse is THELMA BELLE FORBES, University of Oklahoma School of Nursing, 1937, also have MAJOR WENDELL J. MERCER, O. U., 1925 from Enid, and LT. HOE E. HARMISON, O. U. Pharmacy, 1940 from Frederick, Oklahoma.

"We have set up in both tents and buildings at present are in a group of German Hospital Bldgs. with steam heat, electricity and water, but expect to go back to tents next time.

"I see KENNETH BREWER, NEB MILLER and REX BOLEND occasionally. Sure will be glad when this thing winds up, have hopes of coming home when the fight is over in Germany, but may have to go over and participate in the Jap fight. Sure hope not as I am on my fifth years of service now."

LT. C. A. ROYER, Alva, reports from the South Pacific and states that he is tired of sitting on a 'bare coral island' for a year and a half. (Here's hopin' you can come on home, Lt. Royer).

LT. O. L. PARSONS, Lawton, has reported for active duty with the Navy.

COLONEL R. N. HOLCOME, Muskogee, is in charge of the overall, three-way program, mental, physical and medical at the Percy Jones Hospital Convalescent Hospital at Ft. Custer, Michigan. The hospital is one of the army's educational and rehabilitation centers.

LT. G. G. DOWNING, Lawton and LT. C. L. CALDWELL, Chelsea, have reported for active duty with the Navy.

COL. W. P. NEILSON, Enid, writes from Belgium as follows: "I am sure that there is no other State Association within the union of dear old U.S.A., who has done more for their absent brethren than Oklahoma.

"I most certainly look forward to receiving the letters and know that only a sincerity of purpose, motivated by a genuine desire to render an unselfish service to we who are absent could impel the continuation of our interests so persistently.

"Perhaps Dr. Tom, with his 'slightly damaged' heart, as he states, has a degree of cardiac warmth that more than compensates for the dysfunction with the radiation of unselfishness." (We will now say THANKS in caps).

We have Greetings — and Cheerio from MAJOR HERVEY A. FOERSTER, Oklahoma City, who is billeted in London. He says that the English weather has been quite nice and he is enjoying attending the Royal society of Medicine meetings.

LT. R. G. RAY, Tulsa, writes from 'at sea' as follows:

"I have seen almost all of the Pacific, in fact, too much of it and have taken part in seven invasions, namely, Tarawa, Kwajalein, Saipan, Guam, Leyte, Longayen Gulf on Luzon and Iwo Jima and I have had

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In this stepped-up tempo of war, however, the Army doctor finds little "time out" for himself. When there is a "break" in his long hours, his relaxation may be limited to a few pleasant moments with a cigarette... very likely a Camel, for Camels are such a big favorite with men in all the services.

Camel

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plenty of surgery to do at times along with travel. That covers the highlights of my little part in this big war and now all I want is to hurry and get the whole thing over with so that we may return to our homes again. In fact, I'm hoping for orders one of these days that will take me back."

The following letter was received by the University of Oklahoma School of Medicine from COLONEL LEE K. EMENHISER, Oklahoma City, now at Ft. Sam Houston, Texas.

"The day's work is over, everyone gone home but me, so I will write all of you at the same time by using carbon copies and thereby answer the letters I have received from you from time to time.

"It is nice weather in San Antonio now and I have my garden all planted — I surely am going to have a good garden started for whoever moves in my quarters — every year I plant a garden expecting that some one else will use it but so far, I have no orders.

"MAJOR SNOW (J. B. Snow, Oklahoma City) is busier than ever with Pediatrics and is ready for foreign duty as he says no assignment in the world could make him go nuts faster than seeing so many babies a day and he gets all the serious cases from this part of Texas. MAJOR CLYDE KERNEK (Holdenville) is busy getting the convalescent addition ready. MAJOR ROBERT NOELL, Oklahoma City is busy in Orthopedies here. Snow, Kernek, Noell and I are the only permanent B.G.H. staff members from Oklahoma at present. CAPTAIN J. R. HUGGINS, Oklahoma City, was here for a while but is back at Borden General Hospital for his hearing defect as he is totally deaf in one ear and mostly deaf in the other. CAPTAIN JIMMY RICKS, Oklahoma City, returned her from the Pacific Area but has been transferred out. I had a good visit with CAPTAIN RUGIE COATES, Oklahoma City, last month and he is glad to be back from the Southwest Pacific.

"MAJOR HARRY FORD, Oklahoma City, wrote me from Paris where he is with a good General Hospital doing clinical ENT work and likes it better than when he was in the combat area where once in a while his outfit would be close to firing; he saw BYRON CORDONNIER, JERGENSON, and LOU CHARNEY and also MAJOR CRADEN. Craden is still in England.

MAJOR GEORGE T. ALLEN is a flight surgeon at Assam, India and received some cigars we sent him — he gets plenty of cigarettes which he does not smoke and trades them for cigars which are rationed 4 per month; snakes and monkeys are numerous around the tents but work goes on. MAJOR CHARLES WILSON was stationed here awhile but has been transferred to a foreign duty hospital.

"LT. COMDR. GERALD ROGERS and LT. HARRY DEUPREE are at the Navy Hospital at Norman, Oklahoma awaiting assignment the last time I heard.

"There are over 800 Trench Feet cases here now and lots of them require amputation of toes and feet — a shame. Our Chest Surgery center is enlarging and the Chest Surgeon wants to do all the bronchoscopies which he does but does not want to do the esophagoscopies so I do those and the retrograde dilations; those U. S. soldiers should quit drinking wine they find with lye in it as it is lots of trouble dilating them.

"Nearly all of B.G.H. hospital staff is now composed of doctors that have been on foreign duty and that is the right way — only three have been here longer than I.

"Well, will see you sometime, overhere or overthere, damn if I know — you guess."

CAPTAIN JOHN V. CLARK, Oklahoma City, writes that he expects to get a panoramic view of the blue Pacific soon. He says, "I don't keep very well informed about the old gang but if you see anyone that per chance knows me give them my regards and just say I'm counting the years (?) until I get back."

"The 'Clearing Company' of the 45th Infantry Division has recently been awarded the Award of Meritorious Service Unit Plaque which entitles individuals in the unit to wear the insignia while still assigned or attached to the unit.

"The Clearing Company was formerly designated as H Company — home station is Oklahoma City.

"This is really a crack medical unit and is serving in its fifth campaign." The above comes from CAPTAIN CARSON L. OGLESBEE, Muskogee, who, incidentally, was written up in Ernie Pyle's "Brave Men."

LT. COL. D. M. GORDON, Ponca City, has recently been advanced from Major.

Freed from German Prison Camps and returned to the United States, are CAPTAIN CURT YEARY and MAJOR HAROLD F. BERTRAM.

RESOLUTION

WHEREAS, it is the duty, responsibility and privilege of each member of our sovereignty to help support the sacred privileges that we all hold dear

AND WHEREAS one of the members of District 1 has carried the torch by protecting such rights in World War I along with his beloved wife who served on the home front

AND WHEREAS one of his sons has made the supreme sacrifice in World War II, it is the bonded duty of each of us, as colleagues, that we take due notice of such outstanding devotion to duty by calling attention to each and every member of the Oklahoma State Medical Association

AND REQUEST that a copy of this Resolution be sent to our beloved colleague, a copy spread on the minutes of this meeting and a copy be printed in the Journal of the Oklahoma State Medical Association.

THEREFORE, I, V. C. Tisdal, President of the Oklahoma State Medical Association, do hereby request that the members of District I of the Oklahoma State Medical Association herein assembled do hereby dedicate a period of silent prayer asking the Almighty to continue to give proper support and comfort to Dr. and Mrs. C. W. Tedrowe in the loss of their son.

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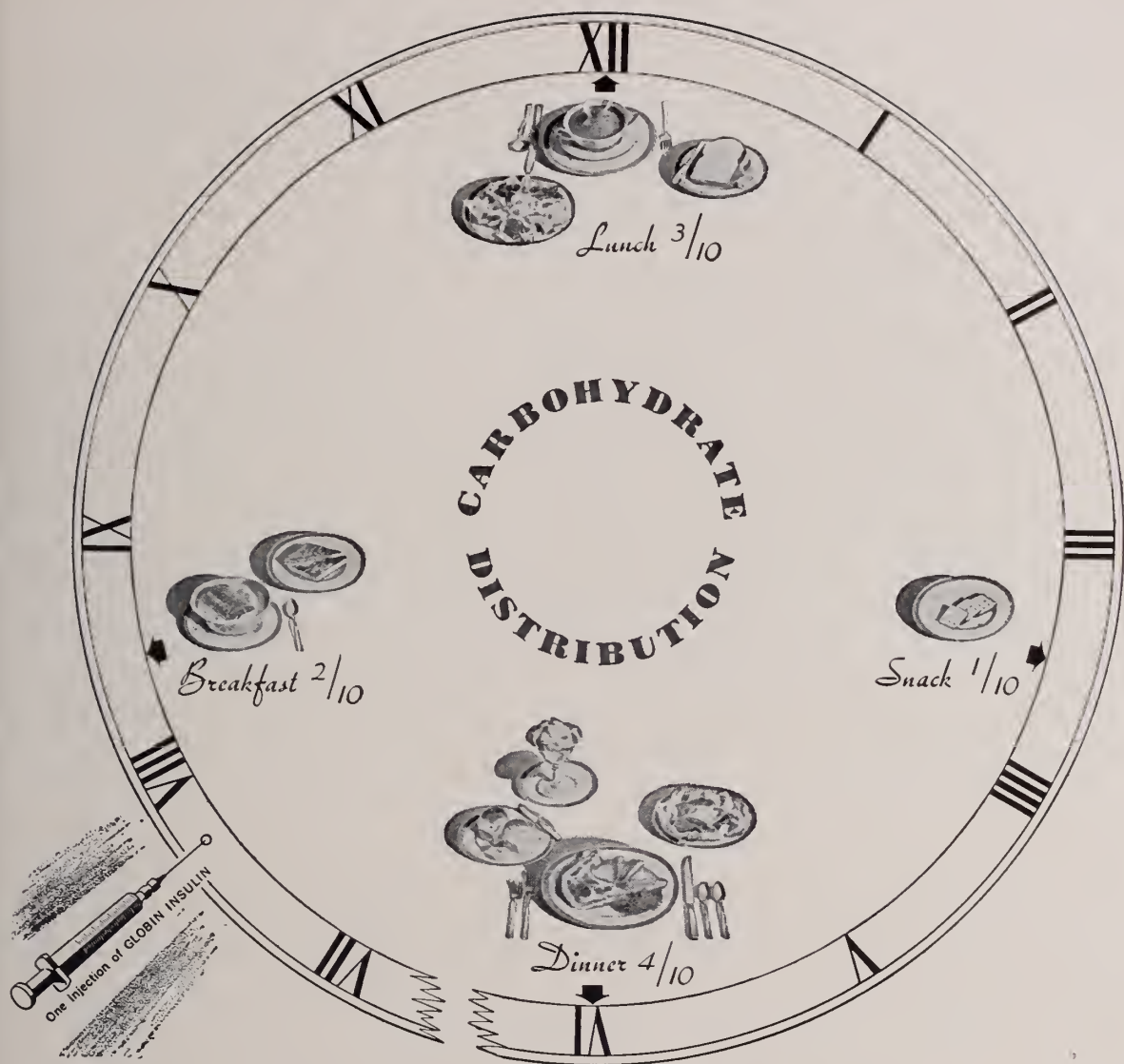
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MEDICAL ABSTRACTS

VITAMINS IN OTOLARYNGOLOGY. H. B. Perlman. *The Annals of Otolaryngology and Laryngology*. St. Louis, Vol. 3, pp. 27-273. June, 1944.

There is now a widespread interest in the use of vitamins. The doctor and the layman are exposed equally to the untoward effects of advertisements and inaccurate information.

Vitamin A deficiency produces xerophthalmia and night blindness in man. In reviewing the clinical picture from reports of these cases and postmortem findings there is very little evidence of ear, nose or throat pathology. An occasional report of metaplasia of the bronchial and sinus mucous membrane appears in the autopsy findings.

Vitamin B1 or thiamine deficiency produces a disease called beri-beri. The clinical picture is that of multiple neuritis, but in the clinical and pathological reports of these cases otolaryngological signs are singularly scarce. Furthermore this vitamin may be synthesized in the human intestinal tract.

Nicotinic acid deficiency causes pellagra. Ulcerations in the mouth and glossitis are the principal otolaryngological signs. A dry esophagitis with ulcers was also present in a number of pellagra patients. Often associated with this deficiency is riboflavin deficiency, another vitamin B fraction. Inflammation of the lips and ragades about the corner of the mouth and nose appear to be its principal signs. The mouth ulcers seem to become infected with Vincent's organisms and respond to nicotinic acid therapy.

Vitamin C or ascorbic acid deficiency may go on without producing any other symptoms but loss of weight. Low ascorbic acid has been found in a few cases of gingivitis at the dental clinic, one or two patients having irritations from dentures. These have responded to as-

corbic acid therapy. No other otolaryngological signs have been observed.

Vitamin D deficiency produces the clinical picture of rickets. Again no otolaryngological signs are common to this deficiency state. No other known clinical vitamin deficiency states are known although the tocopherol of vitamin E appear to be concerned with the reproductive and nervous functions in animals and vitamin K is important in the formation of prothrombin.

Criteria for defining known deficiency states in man are still in the process of formulation. Until these criteria are established the subclinical vitamin deficiency states cannot be seriously considered. In the otolaryngological literature a number of articles have appeared in which the author has attempted a correlation between vitamins and the diseased states. Yet, in none of these was the evidence for a vitamin deficiency state convincing. Neither were the therapeutic results conclusive.

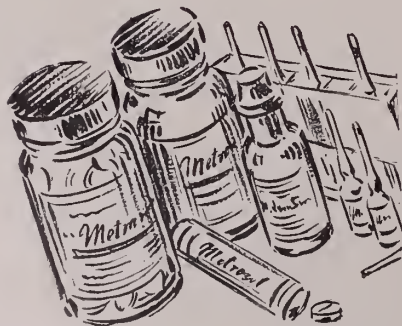
In contrast to many poorly controlled clinical studies the controlled animal experiment and the biochemical studies continue to bring new light on the physiology of the vitamins and suggest possible ultimate application to otolaryngology. However, extreme caution should be exercised in transposing the results of vitamin experiments on animals to the clinic.

The use of vitamins for a transitory pharmacologic effect — as, for example, producing vasodilatation with nicotinic acid — may be mentioned only to point out that it is not directed towards correcting a specific deficiency state. One cannot expect to relieve a long standing pathological process by inducing a non-specific pharmacologic effect lasting only a few hours. Only changes in transient symptoms may be expected by such treatments.—M.D.H., M.D.

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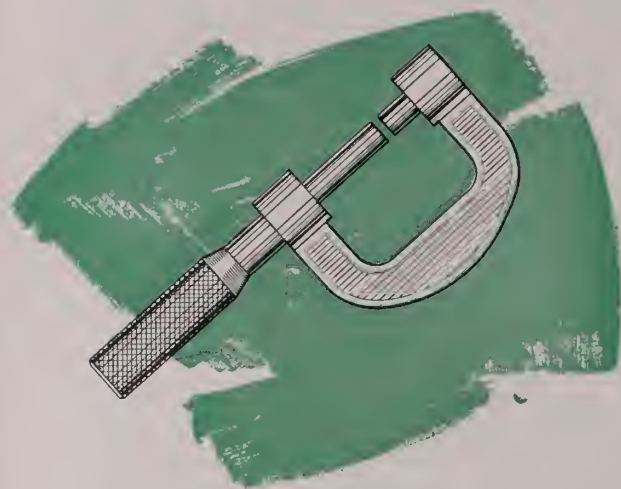
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OCULAR NEUROSIS. A. M. G. Campbell and A. G. Cross. *The British Journal of Ophthalmology*, Vol. 28, pp. 394-402. London. August, 1944.

Ocular symptoms may exist in the absence of any organic lesion of the eyes, or may appear to be of a severity which is disproportionate to the pathological condition. Cases showing these symptoms are neurotic in type and are particularly numerous in wartime. The authors state that this condition is very frequent on the British Isles, where about 34 per cent of the cases of eye complaint is of psychological origin among members of the Armed Forces.

A history of previous nervous breakdown in the patient or his family is often present, and childhood traits of neurotic origin may be reported. Unhappiness in childhood and parental strife may also form a background. The occupation, climate, and contentment of the patient in his surroundings are important factors. Those who work in underground rooms commonly complain of ocular strain, which they attribute to bad lighting, though the illumination may be very good. Men who believe that they have "weak eyes" often manifest ocular anxiety symptoms as a result of a conviction that the heat and glare of the tropics will have adverse effect on their vision. Exposure to wind and weather may lead to the development of neurotic symptoms. The eyes are among the most usual organs of the body to be involved in the manifestations of neuroses because everyone is sensible of their importance in the living of a normal life. Separation from home and family and the inability to deal adequately with domestic situations may cause ocular anxiety symptoms.

Hysteria and anxiety states are prone to occur after head injuries and functional amblyopia is found not infrequently. Organic damage of the globe and temporary or permanent paresis of ocular muscles may be the result of accompanying injuries.

Flying and the strain which it may entail is an important factor in the production of ocular neurosis in all members of aircrew, who depend for their very existence on the continuing efficiency of their eyes under the most trying conditions. A pilot who begins to lose confidence and judgment in landing or in formation flying is apt to blame his eyes and not his mental make-up.

The failure of vision varies in degree from complete blindness in both eyes to a mild defect in one eye. The field of vision is usually contracted and it may be irregular. Eye-ache, eye-strain and tiredness of the eyes are common complaints in neurotic patients. The pain is frequently exaggerated, and they rarely disturb sleep. There may be also photophobia and excessive blinking, but there is usually no abnormal conjunctival congestion. Diplopia is a common complaint; if present at the time of examination, it is frequently found to be due to a deficiency of convergence. It should be emphasized that cases of neuroses are essentially polysymptomatic and that two or more of the above symptoms usually occur in the same patient. Symptoms tend to be contradictory, and signs to be irregular, as compared with organic conditions.

The treatment of such cases depends on how much value reassurance of the patient will have in clearing his his symptoms, and will only be really effective in a patient whose basic personality is sound. The prognosis of cases where real fear of disease exists is good because careful examination and re-assurance often cures them. Where the conflict is deeper and is bound up with various fears and troubles intimately connected with Service life the prognosis for future service is poor.—*M.D.H., M.D.*

KEY

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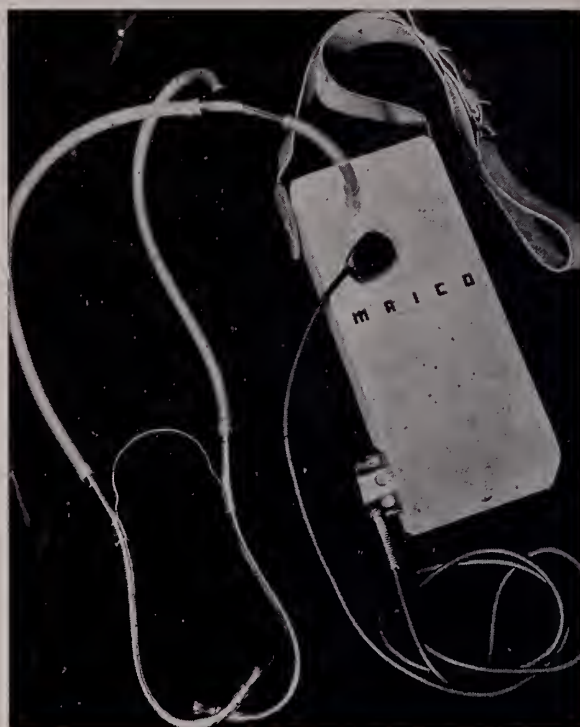
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THE MONKEY'S VIEWPOINT

Three monkeys sat in a cocoanut tree
Discussing things as they're said to be.
Said one to the others, "Now listen, you two—
There's a certain rumor that can't be true,
That man descended from our noble race.
Why, the very idea! It's a dire disgrace!

No monkey ever deserted his wife,
Starved her baby or ruined her life.
And you've never known a mother monk
To leave her young with others to bunk
Till they scarcely knew their mother.

And another thing you'll never see—
A monk build a fence around a cocoanut tree
And let the cocoanuts go to waste
Forbidding all other monks a taste.
Why, if I build a fence around this tree
Starvation would force you to steal from me.

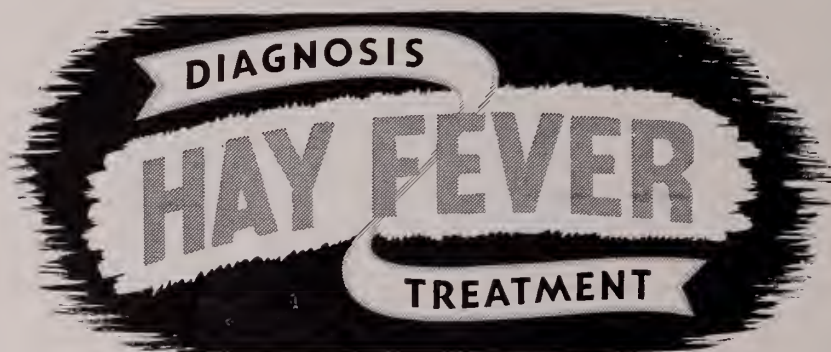
Here's another thing a monk won't do;
Go out at night and get on a stew;
Or use a gun or a club or a knife
To take some other monkey's life.

Yes, man descended, the onery cuss,
But brother, he didn't descend from us.
Anon.

Death

Come, lovely and soothing death,
Undulate round the world, serenely arriving, arriving,
In the day, in the night, to all, to each,
Sooner or later, delicate death.

—Walt Whitman. *A Physician's Anthology
of English and American Poetry*, p. 328.



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OFFICERS OF COUNTY SOCIETIES, 1945



COUNTY	PRESIDENT	SECRETARY	MEETING TIME
Alfalfa.....	H. E. Huston, Cherokee	L. T. Lancaster, Cherokee	Last Tues. each Second Month
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Beckham.....	G. H. Stagner, Erick	O. C. Standifer, Elk City	Second Tuesday
Blaine.....	Virginia Curtin, Watonga	W. F. Griffin, Watonga	
Bryan.....	W. A. Hyde, Durant	W. K. Haynie, Durant	Second Tuesday
Caddo.....	C. B. Sullivan, Carnegie	P. H. Anderson, Anadarko	
Canadian.....	P. F. Herod, El Reno	A. L. Johnson, El Reno	Subject to call
Carter.....	J. L. Cox, Ardmore	H. A. Higgins, Ardmore	Second Tuesday
Cherokee.....	P. H. Medearis, Tahlequah	W. M. Wood, Tahlequah	First Tuesday
Choctaw.....	O. R. Gregg, Hugo	E. A. Johnson, Hugo	
Cleveland.....	Iva S. Merritt, Norman	O. M. Woodson, Norman	Thursday nights
Comanche.....	W. F. Lewis, Lawton	W. C. Cole, Lawton	
Cotton.....	G. W. Baker, Walters	Mollie F. Scism, Walters	Third Friday
Craig.....	Lloyd H. McPike, Vinita	J. M. McMillan, Vinita	
Creek.....	C. R. McDonald, Mannford	Philip Joseph, Sapulpa	
Custer.....	T. A. Boyd, Weatherford	W. H. Smith, Clinton	Third Thursday
Garfield.....	P. W. Hopkins, Enid	John R. Walker, Enid	Fourth Thursday
Garvin.....	Marvin E. Robberson, Wynnewood	John R. Callaway, Pauls Valley	Wednesday before Third Thursday
Grady.....	Roy E. Emanuel, Chickasha	Rebecca H. Mason, Chickasha	Third Thursday
Grant.....	I. V. Hardy, Medford	F. P. Robinson, Nash	
Greer.....	R. W. Lewis, Granite	J. B. Hollis, Mangum	
Harmon.....	W. G. Husband, Hollis	R. H. Lynch, Hollis	First Wednesday
Haskell.....	William Carson, Keota	N. K. Williams, McCurtain	
Hughes.....	H. A. Howell, Holdenville	Imogene Mayfield, Holdenville	First Friday
Jackson.....	C. G. Spears, Altus	E. A. Abernethy, Altus	Last Monday
Jefferson.....	F. M. Edwards, Ringling	J. I. Derr, Waurika	Second Monday
Kay.....	Dewey Mathews, Tonkawa	G. H. Yeary, Newkirk	Second Thursday
Kingfisher.....	B. I. Townsend, Hennessey	A. O. Meredith, Kingfisher	
Kiowa.....	J. P. Braun, Hobart	William Bernell, Hobart	
LeFlore.....	Neeson Rolle, Poteau	Rush L. Wright, Poteau	
Lincoln.....	U. E. Nickell, Davenport	C. W. Robertson, Chandler	First Wednesday
Logan.....	J. L. LeHew, Jr., Guthrie	J. E. Souter, Guthrie	Last Tuesday
Marshall.....	J. L. Holland, Madill	J. F. York, Madill	
Mayes.....	S. C. Rutherford, Locust Grove	B. L. Morrow, Salina	
McClain.....	J. E. Cochran, Byars	W. C. McCurdy, Jr., Purcell	
McCurtain.....	J. T. Moreland, Idabel	R. H. Sherrill, Broken Bow	Fourth Tuesday
McIntosh.....	J. Howard Baker, Eufaula	Wm. A. Tolleson, Eufaula	First Thursday
Muskogee-Sequoyah			
Wagoner.....	H. A. Scott, Muskogee	D. Evelyn Miller, Muskogee	First Monday
Noble.....	D. F. Coldiron, Perry	Jess W. Driver, Perry	
Okfuskee.....	W. P. Jenkins, Okemah	M. L. Whitney, Okemah	Second Monday
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Okmulgee.....	W. M. Haynes, Henryetta	J. C. Matheney, Okmulgee	Second Monday
Osage.....	G. K. Hemphill, Pawhuska	C. R. Weirich, Pawhuska	Third Monday
Ottawa.....	P. J. Cunningham, Miami	L. P. Hetherington, Miami	Second Thursday
Pawnee.....	E. T. Robinson, Cleveland	R. L. Browning, Pawnee	
Payne.....	Haskell Smith, Stillwater	A. C. Reding, Stillwater	Third Thursday
Pittsburg.....	L. N. Dakil, McAlester	A. R. Stough, McAlester	Third Friday
Pontotoc-Murray.....	Ollie McBride, Ada	R. H. Mayes, Ada	First Wednesday
Pottawatomie.....	Chas. W. Haygood, Shawnee	Clinton Gallaher, Shawnee	First and Third Saturday
Pushmataha.....	John S. Lawson, Clayton	B. M. Huckabay, Antlers	
Rogers.....	K. D. Jennings, Chelsea	Chas. L. Caldwell, Chelsea	Third Wednesday
Seminole.....	A. A. Walker, Wewoka	Mack I. Shanholtz, Wewoka	Third Wednesday
Stephens.....	W. K. Walker, Marlow	E. H. Lindley, Duncan	
Texas.....	R. G. Obermiller, Texhoma	Morris Smith, Guymon	
Tillman.....	W. A. Fuqua, Grandfield	O. G. Bacon, Frederick	
Tulsa.....	H. A. Ruprecht, Tulsa	E. O. Johnson, Tulsa	Second and Fourth Monday
Washington-Nowata.....	J. V. Athey, Bartlesville	S. A. Lang, Nowata	Second Wednesday
Washita.....	A. S. Neal, Cordell	James F. McMurphy, Sentinel	
Woods.....	O. E. Templin, Alva	I. F. Stephenson, Alva	Last Tuesday
Woodward.....	Roy Newman, Shattuck	C. W. Tedrowe, Woodward	Odd Months Second Thursday

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The Thymus Gland and Its Relationship To Myasthenia Gravis

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Since 1901 when Weigert found a thymic tumor at necropsy in a patient who had died with myasthenia gravis, many observations have occurred and have been reported.

Clinical observations of patients frequently serve as stimuli for scientific studies and experimentation. Myasthenia gravis is an example of one such syndrome. There was a time when the condition appeared to be a specific clinical entity. It would now seem that myasthenia is a manifestation of a not yet understood disturbance of the chemistry relating to the myoneural junction. McEachern (1) reports that there is tumor formation in the thymus in about 50 per cent of cases clinically diagnosed as myasthenia gravis. However, he points out that myasthenic symptoms also occur in hyperthyroidism, adrenal cortex deficiency, and after castration. In these three conditions there exists muscular asthenia, creatinuria, and hypertrophy of the thymus gland. His studies failed to disclose any specific chemical substance to account for the muscular weakness.

The thymus gland weighs from 14 to 20 grams at birth. It gradually increases, so that at 15 years of age it weighs from 25 to 40 grams. From the age of sixteen onwards, there is a gradual diminution in size so that at the age of forty-five to sixty years, the gland weighs from 3 to 9 grams.

Sloan (2) made examinations of thymus glands in 350 autopsies. There were ten cases of myasthenia gravis in the series. He did not find specific changes, but did report that pathologic alterations occurred, in the cases of myasthenia, but they were in no way different from the changes found in the thymus gland associated with other diseases. This

would indicate therefore, that the thymus gland becomes pathologic in certain conditions in which myasthenia is the presenting clinical symptom.

Viets et al, (3) have reported several cases in which the symptoms of myasthenia gravis became greatly alleviated during pregnancy. This would indicate that an as yet not understood endocrine disturbance is involved in the process.

The literature on the subject is becoming quite voluminous, but attention is especially called to recent surgical removal of the thymus as reported by Blalock and associates. (4). In 1936, removal of a cystic tumor of the thymus, measuring about 6x5x3 in., gave complete freedom from all muscular weakness and a return to normal health. The patient was observed for three years before a report of the surgical procedure was published. At that time she was able to swim, dance, play tennis, talk normally and hike as much as ten miles a day without undue fatigue.

A preliminary review of the results of total thymectomies in six cases of myasthenia gravis was given at the same time. Each of these patients had persistent and enlarged thymus glands, none had cystic or solid tumor formation that was determined grossly. One patient in this series died from a post-operative mediastinitis. Each of the other five obtained definite and increasing relief from the myasthenic symptoms within six weeks after thymectomy, and steady improvement thereafter.

In 1942, Campbell (5) reported two additional cases upon which thymectomy had been performed for relief of myasthenia

gravis. These patients had definite spherical tumor formation in the thymus gland. One patient died shortly after surgery. The other remains very much improved, although mild myasthenic symptoms persist after operation.

The syndrome of myasthenia gravis occurs at any age. Cases have been reported as definite problems of infancy. Kawaichi (6) reports the condition in an infant 21 months old, and cites other reports by pediatricians.

As stated above, myasthenia is a symptom. The quantitative component is the criterion for more serious clinical considerations.

As a rule, the presenting symptoms that would arouse the physician's suspicion are, ptosis and involvement of the muscles supplied by bulbar innervation, which becomes progressively more involved with exercise. The patient is usually free of symptoms after rest, but, as the day goes on, double vision occurs, the speech becomes nasal in character, and some difficulty in swallowing develops. Later, general weakness occurs after exercise, and the patient becomes a semi-invalid.

Prostigmine, and ephedrine give symptomatic relief in most cases. This relief has proven to be only of temporary value, however, and ultimately, the patient does not respond to this medication.

It should be mentioned however, that prostigmine, in doses from 0.5 mgm. to 2 mgms, is a fairly reliable therapeutic test in these individuals (Eaton) (7). A relief from symptoms occurs in from five to ten minutes after subcutaneous injections of prostigmine. In some cases, it is preferable to give ten grains of quinine orally. If the myasthenic syndrome is present, the symptoms will become much worse in from one to two hours after taking quinine.

In patients who complain of fatigue upon exertion, it would be well that these therapeutic tests be carried out, because neurasthenia, or neurocirculatory asthenia may, as a result of discoveries relative to the thymic gland disturbance, become included in the domain of alleviative therapy.

This is a report of surgical removal of the thymus gland in a patient with myasthenia gravis whose symptoms had existed for many years. Satisfactory improvement did not follow surgery, because of the fact that secondary complications had developed and were of long standing. For example, the facial muscles had undergone pronounced atrophy and fibrosis (Fig. I). The muscles involved in deglutition had likewise perished. There was also generalized atrophy of muscle tissue, which could not be rejuvenated because of the state of degeneration.



Fig. I

However, a very striking enlargement of the thymus gland existed as is shown in the photograph (Fig. II).

It is our belief that, upon the basis of previous reports, and of the findings disclosed in this case, that conditions of myasthenia should be very carefully studied, with special reference to the thymus gland.

Unfortunately, roentgenographic studies have been negative in most cases. Apparently the thymic tissue, although enlarged, does not produce a discernible x-ray shadow. The evaluation of symptoms therefore, is resolved to the matter of clinical judgment.

Patients with symptoms that indicate existing or beginning myasthenia should first be given prostigmine and ephedrine. When symptoms become progressive after alleviation by these drugs has ceased, then the matter of exploration of the mediastinum should be seriously considered.

It is our opinion that the enlargement of the thymus gland is only a manifestation of some as yet not discovered etiological entity, but symptomatic relief in such a malignant disorder as myasthenia gravis by removal of the thymus gland is indicated, in the present state of our knowledge, after failure of adequate relief with prostigmine or ephedrine. Even though relief from thymectomy is obtained in only 50 per cent of the cases, at

least an explanatory operation and removal of any thymus gland tissue should be done.

REPORT OF A CASE

Mrs. N. C., age 35.

History: Normal birth and development. Sister died of pneumonia age one month, and a brother died at age 2 weeks from pneumonia. One sister and five brothers, ages 21 to 38, all living and well, except for one brother, 25, who had epileptic seizures.

Married, three children, ages 8, 14, 16, all in good health. One miscarriage.

Present Illness: In 1932, Mrs. N. C. first noticed diplopia, which glasses did not correct. Worse in evenings, better in mornings. Diplopia has been present continuously until this hospital admission, except for a few short remissions.

Weakness of the soft palate, muscles of mastication, and facial expression, came on gradually, and by 1941 were so pronounced that food was difficult, to impossible to swallow, while liquids ran up the nasal passages,

out the nose. Swallowing function always seems normal, but food lodged in her mouth and she could not move it to the esophageal opening.

The thyroid gland became prominent in 1941, and the patient was given X-Ray therapy over the gland by a physician. This treatment did not relieve her muscle weakness nor reduce the size of the thyroid gland.

Weight loss has been marked since 1941. Until age 30, the patient's weight remained at 112 to 118 pounds, and height 64 inches. At age 35, weight dropped to 80 pounds and concomitant has been a gradual loss of strength on the arms, legs, entire muscular system.

Menstrual periods have been entirely normal; during her entire pregnancy in 1936, she had complete relief of all weakness, even diplopia. But the myasthenia returned within ten days post-partum.

No palpitation or shortness of breath. No swelling of feet or hands at any time. Pain, except for toothache, not present. No muscle cramping. Bowel function entirely normal. Occasional incontinence when myasthenic symptoms most pronounced.

Has seemed to be most affected in December, January, and in July, August. Subject to colds in winter, and coughs in four or five weeks with even a mild choryza.

Medications Prostigmin, 30 to 50 mg. per day by tablet, since 1942, and as many as 4 hypodermic solution 1:2000 injections.

Ephedrine, gr $\frac{7}{8}$ with each prostigmin tablet. Partial to complete relief of all symptoms within twenty minutes of prostigmin ephedrine medication, lasting one to three hours.

Foods: No selective food craving, but prefers pancakes, ground meat, and any food easy to masticate and swallow.

Admitted to Coyne Campbell Sanitarium July 16, 1944 for study and observation. Transferred to St. Anthony's Hospital July 21, 1944. Given Prostigmin injections three to four times a day, two 500cc plasma transfusions and one blood transfusion of 500cc. The plasma and blood transfusions gave nearly complete relief of myasthenia for fourteen to twenty-four hours, without necessity of prostigmin.

Operation: J. M. Campbell, July 27, 1944.

Endo-tracheal oxygen, with ether anaesthesia given by Dr. Lois Wells. Very little ether found necessary after induction was complete.

The sternum divided longitudinally from the manubrium to the fifth body of the sternum. Right and left mediastinal reflections of the pleura retracted laterally giving good exposure to the entire anterior mediastinum.

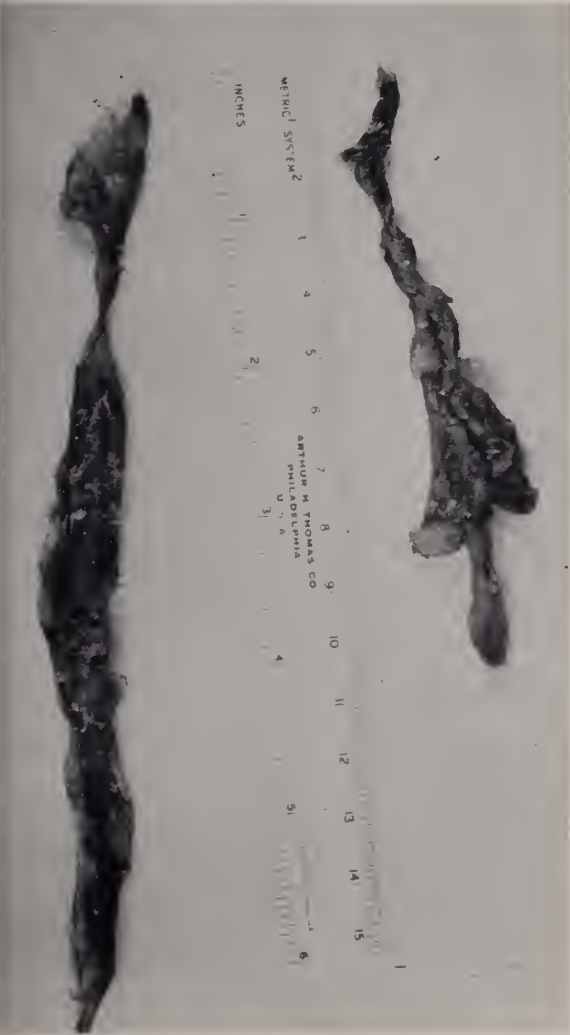


Fig. II

Thymus gland on right extended from the inferior pole of right Thyroid lobe to the superior pericardium, a length of about 16½ cm. Thymus gland on left extended from the inferior pole of left Thyroid lobe to the superior pericardium, a length of about 11 cm. A thorough search did not reveal any aberrant Thymus tissue.

Wound closed with interrupted silk and patient in good condition. Operation time 65 minutes. A blood transfusion was given during operation, and pulse did not exceed 88 at any time.

POST OPERATIVE COURSE: The patient had a remarkable absence of post operative reaction. Pulse never reached 96 at any time except after a slight fluid reaction from intravenous glucose. Placed on soft diet on third day, out of bed on sixth post operative day was able to walk eight blocks. Incontinence was present while in bed, disappeared when she was able to exercise.

Follow up of this case fails to indicate any appreciable improvement as a result of the surgery. However, as explained above, the extensive amount of muscular atrophy and fibrosis that had developed as a result of the prolonged existence of the disorder precluded the expectation of satisfactory clinical results. The pathologically persistent thymus gland, as shown in the photograph had undoubtedly existed for many years. If it had been removed earlier, it is our opinion that the patient would have likely acquired a recovery from her disorder, as has been reported by other investigators.

SUMMARY

(1) It is likely that myasthenia gravis is a condition resulting from some as yet not understood disturbance of chemistry involved in the myoneural junction.

(2) Myasthenic symptoms also characteristically occur in hyperthyroidism, adrenal cortex deficiency, and castration.

(3) The prostigmine and quinine tests should be used in suspected cases.

(4) Pregnancy brings about an alleviation of symptoms.

(5) The thymus gland is enlarged and shows pathology in about 50 per cent of cases of myasthenia gravis.

(6) The thymus gland becomes pathologic in certain conditions in which myasthenia is the pathologic symptom.

(7) The enlarged thymus is not demonstrable by x-ray technique.

(8) Surgical exploration of the mediastinum, and thymectomy is indicated in those cases not adequately relieved by medical measures.

(9) This surgical procedure should not be postponed if muscular atrophy develops accompanied by inadequate relief from prostigmine.

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Some Gynecologic Conditions Arising in The Cervix and their Treatment*

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No greater progress has been made in any department of medicine in this generation than that of gynecologic disease. We note with great satisfaction the transition from preponderantly radical scalpel surgery to that of conservative measures in the majority of cases. Advent of relatively simple means of eradicating chronic infections of the cervix-uteri has contributed most to relief of the prevailing ailment of the female. It is axiomatic that twenty-five per cent of virgin and nulliparous females and almost a

hundred per cent of parous ones, are victims to some degree of cervical infection. Speculation on reason for prevalence of the malady is based on the ever present multitude of organisms inhabiting the vagina and adjacent urinary and rectal apertures, with the introduction of others through coitus, insertion of contaminants and the trauma of abortion and parturition. While it appears that nature's barriers are interrupted largely by trauma, there are some so-called aseptic erosions seen in virgins that are from constitutional discrepancies.

*Presented at November 1944 meeting, Oklahoma City Society of Gynecologists and Obstetricians.

A brief review of the histologic nature of the cervix and contiguous circulatory ramifications will facilitate understanding of pathologic alteration in pelvic extension. Fusiform shape of the cervical canal, studded with horizontally situated deep penetrating glands whose columnar epithelium secretes a mucoid lubricant for the vagina and protection of spermatozoa in fertilization, is highly conducive to microbe invasion, because of the favorable medium afforded germ and parasitic implantation and the retention of these products from narrowing of the outlet to the reservoir. The proximal end of internal os being smaller seems to be nature's provision for obstructing upward extension through this aperture. Infection of these slender ducts with swelling of epithelial lining obstructs both drainage and introduction of medicaments, resulting in production of granulations at the mouth of the glands as epithelial cells become everted to complete the picture commonly designated cervical erosion.

Lymphatic circulation is of paramount significance in visualizing extensions of cervical disease, as it is the medium through which most occur. Blood stream invasion is always a possibility, but is relatively infrequent. The rich lymphatic network of the cervix ramifies the corpus and adnexa abundantly, terminating in larger collecting trunks laterally that extend along the vertebral column to the diaphragm. Accompanying sympathetic ganglia accounts for symptoms sometimes seeming foreign to the suspected lesion.

As in other infections, those of the cervix are classified acute and chronic. The acute infections are managed in a most conservative manner commonly responding to well known measures of local hygiene, chemotherapy, drainage and general support, terminating shortly in complete resolution or residual focalization.

The chronically diseased cervix, however, shows little inclination toward self restitution and accounts for a vast majority of symptoms to which the female is heir. So incipient is the onset and progress of cervical disease that many are wholly unaware of its presence, while others have experienced several or all the symptoms peculiar to the affliction, dating the beginning back to an acute infection, parturition or some other trauma. So disarranged are the cellular elements from prolonged irritation it is not surprising that eighty per cent of all the malignancies in females occur in the vaginal portion of the cervix. Therefore, great responsibility rests with those of our profession having an opportunity to inspect these lesions. It should be a part of routine to visualize the cervix and forewarn the patient of

its potentialities for future trouble, including that of malignancy. The eradication of chronic disease of the cervix has been appraised the greatest possible means of cancer prevention. Furthermore, its importance as a focus of infection responsible for arthritis, phlebitis and many other systemic and metastatic lesions must not be overlooked. In this connection, removal of this focus of infection plays an important role in the prevention of venereal disease, as well as some complications of pelvic surgery. Recently I have had two cases of vicarious menstruation relieved by cervical treatment. Hypertrophy of both cervix and corpus, due to fibrosis produced by long standing inflammation of the cervix, recedes steadily with elimination of infection.

The picture presented in patients with cervical disease is almost stereotype. Leukorrhea, sense of weight and soreness in and on the pelvic floor, dyspareunia, backache, constipation, pelvic pain, menstrual anomalies, preponderantly increased bleeding both in amount and frequency, vesical irritability, nervousness and finally disturbed nutritional and endocrine balance.

Examination discloses visual alteration of the cervix, uterine enlargement and tenderness, often unilateral or bilateral engorgement with soft tumefaction of the adnexa, evincing marked palpable tenderness. The pelvic inflammation may be so extensive that differentiation of salpingitis and appendicitis is difficult. Palpable tenderness so acute and mobilization so fixed it may be designated the so-called frozen pelvis. In any case, save that of acute appendicitis, there is no emergency and exploration should be deferred until the accessible cervical disease has been eradicated. Even the questionable appendix should be managed expectantly. It is lamentable that too many young women presenting themselves for treatment of pelvic symptoms have already been subjected to one or more laparotomies with the loss of tubes and ovaries without beneficial results. Furthermore, curettage and suspension operations have fallen far short of expectations and are now known to have a very limited application. We have all had the unhappy experience of noting within a short time after a very classical suspension of the uterus, its return to former position. Whereas, if the uterine hypertrophy from cervical infection had been reduced with treatment, its own ligamentous support would amply reduce the descensus, as it regains tone to maintain the normal weight intended, identical to that following pregnancy, obviating the necessity for operation or contributing to its success. Similarly, beneficial results from curettage formerly used all too often,

was most likely due to improved drainage through dilation of the cervical canal rather than scraping out the endometrium. Relief of dysmenorrhea by dilation of the cervix, even in the absence of demonstrable pathology, suggests the rationality of maintaining patency in all instances.

Failure to recognize the incidence and importance of cervical disease in pelvic pathology leads to exploratory laparotomy that discloses a chronic lymphangitis, with or without adenopathy, involving the corpus and perhaps one or both adnexa that, from circulatory stasis, is swollen and discolored in passive congestion, while the serosa is roughened from plastic transudate. Malposition of the uterus, hyperemia of the fallopian tubes, multiple unruptured graafian follicles and a conscientious desire to accomplish impossible anticipated results instigate meddlesome plastics or extirpation that not only does not improve symptoms, but likely will aggravate them or add others to the category. Elaborating; versions are entirely normal in some 40 per cent, unruptured follicles, even where they reach to proportion designated ovarian cysts, nearly always recede with time and a majority of tubal inflammations subside with proper therapy. Obviously, with these circulatory impediments ovarian function deteriorates. This brings to mind discouraging hormonal results in disfunctional uterine bleeding. Evidently, efforts should be directed at improving pelvic circulation by elimination of cervical infection, at the same time destroying sanguineous granulations. Marked hypertrophy of the uterus may lead to hysterectomy in young women on the assumption it is a true fibro-myoma. One will be agreeably surprised at the great number of these that will regress following cervical therapy, though they have reached sizeable proportions. It has been my experience in the treatment of cervical disease that the majority of victims may be spared the hazards and added expense of pelvic surgery, with loss of important reproductive organs, invalidism and premature senility that may follow.

Treatment of the chronic cervix has as its objective the destruction of infected glands and neoplastic sequels, all the way from erosion and polyposis through early malignancy, by thermal modality. Formerly scalpel conization of gland bearing structure was much in vogue, but entailed hospitalization and other hazards not so common in modern therapy, in addition to fewer successes and less inclination to acquiescence, that it is now seldom used. Likewise, attempts at cervical repair by suture or excision, or both is being abandoned for modern measures.

Thermal destruction embodies cauterization, coagulation and conization. All of which

have a great deal of merit in the hands of different therapists, and are usually referred to as cautery treatment. However, I should like to make a distinction between the actual cautery and coagulating current, in that we learn from dermatologists the advantages of coagulation over carbonization in minimizing scarring. A timely observation is that every tissue repair, whether from infection or therapeutic trauma, results in some degree of scar formation and that there is a great variable in individuals as to amount. Healing of cervical lesions parallels that of others and it is impossible to foresee keloid formation.

The two cardinal principles of this therapy are adequacy and maintenance of cervical patency. Antagonism of these tax the skill and judgment of the operator, as the more thorough its application the greater likelihood of contracture. There is also recognition of the tendency to constriction of circular musculature from fibrosis incited by infection or other trauma. While cervical treatment may be an office procedure, its relative simplicity should not beget carelessness of application. Familiarity comes from a thorough comprehension of all the principles involved and fineness of judgment acquired only by long experience. In every case it will be necessary to impress the patient with the importance of prolonged observation to forestall or correct intolerable sequela. This is best accomplished, in my hands, by quotation of a fixed fee for the entire service. One must anticipate for them the possibility of postoperative bleeding, contracture, even to the extent of stenosis, future involvement of glands not destroyed, and finally the occasional excitation of an acute flare-up of dormant infection. Bleeding can usually be controlled by simple application of styptic drugs and vaginal packing, but could be sutured. Contracture may be lessened by frequent gentle dilation and negative galvanism insures relaxation of the most severe. Future involvement of glands and inadequate treatment will be managed as in the beginning. Acute flare-up is treated by the same means as acute cervicitis, stressing chemotherapy. Relief of symptoms, with cessation of vaginal discharge, will be obvious within four to eight weeks and the patient will cease to cooperate in follow-up observation at the very time it is most important to prevent contracture, unless remuneration has already been established. Some will experience a gradual improvement over a period of many months, particularly where the condition is of long standing and a great deal of hyperplasia is present. Then in months to come, after apparent success, an occasional case returns with the same or similar symptoms, that means there has been unexpected con-

tinued contraction or that residual infection has gained enough impetus to produce symptoms, usually the former. Visualization does not always clarify this assumption, but experience has taught us the contracture is higher in the cervical canal and will be relieved by a few galvanic treatments within the canal. Therefore, the return of symptoms several years postoperatively does not preclude the possibility of success with additional therapy.

Differentiation of sensitive adnexal masses is usually very difficult, if not impossible. Who professes ability to distinguish cystic ovary, hydrosalpinx, and adnexitis, or to establish a sensitive uterus is not from deep cervical infection or contracture that cannot be seen because the portio has been epithelialized spontaneously or from former treatment? If there be none, let us be sure of the absence of cervical infection, or its removal, and patency of the cervical canal before resorting to radical surgery. It is almost fantastic how many of these will clear up with adequate attention to one or both of these conditions. The escape of menstrual blood through the canal is no assurance of competency. There are many atresic lumina for which there is no accounting that may be the soul cause of pelvic symptoms. Certainly there is too little attention paid to maintenance of free drainage from the cervix and uterus. In the cases of vicarious menstruation mentioned it is my belief that relief was afforded through galvanic dilation and relaxation of the cervix, permitting easy escape of menses.

Detailed discussion of thermal treatment would be voluminous and I shall only mention a very few points that are particularly pertinent. Although the cervix is supplied with a few sensory nerves, there is generally sufficient adjacent tenderness to necessitate some type of anesthesia for adequate manipulation. Insertion of cotton applicator saturated with fifty per cent cocaine for some ten to fifteen minutes is usually adequate. In the very extensive lesions of very sensitive patients fifty milligrams of novocain crystals injected into the subdural space at the third lumbar interspace will insure anesthesia of the region traumatized. This amount of novocain in the position mentioned does not require adjunctive vasoconstrictor drugs, may safely be given in the office and permits the patient to walk out within an hour or so. Insulation of the vaginal canal will prevent accidental injury that occasionally occurs in the most careful technique. The selection of method of treatment must rest with the operator, as in any surgical procedure, and may

be varied to meet individual indications. My own observations lead me to favor unipolar coagulation in young subjects in whom future child bearing must be preserved, as it affords greater conservation of normal tissues. In those of later years electro-conization facilities more thorough destruction and removal of gland bearing structure whose function is no longer important. All gland bearing and other questionable area should be radically coned out, extending wide laterally at the base of the cone, avoiding the internal os. If bleeding is evident and cannot be controlled by focal desiccation, there is no hesitancy in suturing. So many of these subjects will have sufficient contracture to produce symptoms it is mandatory that more than ample galvanism be instituted for relaxation and dilation of the cicatrix. In some post-menopausal cases where secretory function has been totally removed, closure may be permitted if there are no subsequent symptoms. Malignancies of the cervix nearly always arise in the portio, in or near the external os, and unless metastasis has occurred respond to thermal destruction as readily as that of any other locale. Through this medium virtue rests in simplicity of application, conservatism, prophylaxis and eradication of these lesions.

What of the Future?

Before the war, Osler had been one of the great apostles of internationalism, of peace and comity among the nations. When the test came, his service to his country was man-sized and, in the great struggle, he lost his only son. Had he lived to play his part in the great work of reconstruction and reorganization, we may feel sure that he would have insisted that its success will depend upon the attitude of the old toward the young, that the society of the future belongs to the children of the future.—*F.H.G., A Physician's Anthology of English and American Poetry, p. xix.*

Our Osler

What Osler meant to the medical profession in America, what he did for us, can never be adequately expressed. *Omne individuum ineffabile.* And his was an individuality so rare, so warm and radiant with goodwill toward his fellow creatures, that we shall scarcely look upon his like again. He was handsome, wise, witty, learned, courteous, fairminded and brave; with the poet whom he most resembled in happy disposition, he might have said:

To me Fate gave, whate'er she else denied,
A nature sloping to the sunny side.

—*F.H.G., A Physician's Anthology of English and American Poetry, p. vii.*

Hasten the Day

We travelled in the print of olden wars,
Yet all the land was green,
And love we found, and peace,
Where fire and war had been.
They pass and smile, the children of the sword—
No more the sword they wield;
And O, how deep the corn
Along the battlefield!

—*Robert Louis Stevenson. A Physician's Anthology of English and American Poetry, p. 190.*

SPECIAL ARTICLE

NAPOLEON 1769 — 1821 MAN-POWER AND DISEASE

BY LEWIS J. MOORMAN, M.D.

Repeatedly in the columns of the Journal, it has been shown that much of the world's work has been done by the sick and that human destiny can never escape the conditioning effects of disease. In this connection the influence of Napoleon's health upon his habits, his ambitions and his career offers a fertile field for study and research. Even a superficial working of the rich soil yields intriguing facts and uncovers fascinating leads. Biography without psychosomatic consideration is pseudo-biography. In fact, biography never reveals the whole truth because the biographer doesn't know; autobiography is equally unsatisfactory because the autobiographer won't tell. It seems safe to presume that the well trained medical biographer should be able to make the most searching and the most revealing approach to a man's personality and the influences motivating his response to environment.

In Sokoloff's *Napoleon, A Doctor's Biography*¹ we find an interesting study embodying the above principles. In the mill-run of life stories, the influence of health is sadly neglected and when noted at all, it may be woefully misinterpreted for want of adequate medical knowledge. The majority of Napoleon's biographers fail to interpret the influence of his health upon the pattern of his life. Some of them have accepted the vitalizing psychological urge of disease as an indication of physical vigor. As Sokoloff points out, Lord Rosebery asserts that Napoleon was a man of "iron health." For want of medical knowledge with which to interpret and coordinate the facts of health and behavior, he sadly missed the mark. In the foreword to his book, Sokoloff offers the following fundamental psychosomatic reflections:

"This indifferent attitude toward the physical side of man's nature can hardly be justified, if we agree that the evolution of man's personality is one of the most fascinating problems life has to offer. And the greater the man, the greater his role in the life of mankind — the more important becomes the inquiry into those factors which are responsible for the changes in his nature, factors

which may be both physiological and psychological in character.

"In this respect, Napoleon's life offers an exceptional opportunity for such study because of the vividness and sharpness with which this alteration of his character materialized. In him we can observe the evolution of one of the most determined and aggressively active personalities in many centuries into an indifferent, passive, and hesitant person. What factors brought about this dramatic transformation in Napoleon's character, this curious change which was so evident and so undeniable? The answer to this problem may be found in the rich store of available authentic material consisting of the medical records, scrupulously kept by Napoleon's physicians throughout his life, and in the findings of the post-mortem examination of his body. All this medical data allow medical men today to express the opinion that Napoleon was in all probability the victim of an endocrine disturbance — a modification in his ductless glands creating a profound change in his personality.

"Several other questions arise from the study of this material. Was he tubercular, as was the claim of his physician, Antommarchi? Have we any right to affirm, as does Lombroso, that Napoleon was an epileptic? And again, what role did his inheritance play in the development of cancer — the malady responsible for his death? Finally, a question may well be raised as to the effect these illnesses had on his activity."

Because Napoleon died of cancer of the stomach and because his father died of the same malady and presumably his grandfather, his doctors made much of his so-called inherited predisposition to cancer of the stomach. As we survey the facts of his health and attempt to interpret their meaning, we feel that in a broad sense there might have been more reason in the, then accepted, theory that there might have been an inherited tendency toward tuberculosis. The authentic accounts of his health in early life and through the exciting first phase of his active, highly successful military career including the autopsy findings,

warrant the belief that he suffered from pulmonary tuberculosis during this period of remarkable psychological and physical exhilaration, with the inexhaustible urge for power and achievement. Whether we consider this strange psychological flair, with power to drive a physically inadequate constitution on to consummate success, a result of toxemia or an expression of compensatory effort, it seems reasonable to assume that tuberculosis was an important contributing factor.

The history of Napoleon's health and the post mortem report lend credence to the fact that tuberculosis may have had much to do with the "vividness" of his life up to that point where Sokoloff marks the abrupt change in his character and the onset of changes attributed to endocrine imbalance. The psychological and constitutional changes noted at this time suggest the arrestment of the tuberculous condition coincident with changes thought to be endocrine in origin. It must not be forgotten that possibly the cessation of toxemia from an exciting disease (tuberculosis) may have materially contributed toward the unwonted mental calm, general well-being and physical inactivity.

In the following statement from Sokoloff, we find a psychosomatic picture strikingly suggestive of tuberculosis:

"However, as a child, he was of fragile health. Thin and delicate, he could by no means have been called good looking. His head was abnormally large and seemed to balance itself with difficulty on his thin shoulders. He was extremely vivacious, impatient, irritable, and obstinate. When he grew older, this vivacity persisted, but, with time, it gradually changed to aggressiveness."

Physically frail and unattractive, he went to war, as a youth, with uncanny intuition and a strange power to anticipate the answer to military problems, and to drive straight to victory. At first his superiors did not divine this unusual knowledge and foresight but they soon learned not to ignore these qualities originating in the abnormally big head supported by a frail body. Confirming this claim of intuition we reproduce the remarks attributed to Napoleon at St. Helena:

"War is a curious art. I've fought sixty major battles, and did not learn a single thing I had not known before."

Apparently he was leading a charmed life at Toulon. Three horses were killed under him and he survived a bayonet wound in the leg, defying the doctor's orders to remain in bed, he carried on against all odds.

Corroborating the continued appearance of physical inadequacy and disregard of self, we quote Sokoloff:

"He himself is just as bedraggled as the rest. Small and thin, his long pigtailed flapping, he might almost be taken for a girl. The old soldiers pity him, this worn-out, sickly-looking youth. But he does not spare his strength; he throws himself into the thick of battle, inspiring others with his energy and dauntless courage. Their commander, he shares with them the common soldier's lot — eats coarse black bread, sleeps under cannon on rough straw. 'Our Little Corporal,' they nicknamed him familiarly and with affection. . . .

"'For warfare, one needs health,' Napoleon is to say much later. Yet he himself will succeed in proving just the opposite. He will demonstrate that without robust health, one cannot only fight but even win amazing victories. Only dynamic energy and power of spirit are needed.

"His health was weak from his youth. He was often ailing. Thus we see him, a young lieutenant at Auxonne, yellow and thin almost to emaciation. An exhausting fever keeps him off his feet for weeks at a time. In a letter to his mother, in 1789, he complains, 'I've been having continuous fever for quite some time. It lets up, giving me a few days' rest and then returns all over again. It has weakened me and made me delirious. I have been obliged to endure a long convalescence.' But he refuses to go to the infirmary — a hospital regime seems to him unbearable. Refusing all medicine, he continues to work with great energy."

In the light of this report and the subsequent history, one may well suspect an intercurrent attack of malaria.

When summoned by Barras to save the Revolution, he clasped his hands behind his back for a moment's thought (three minutes allowed by Barras) and accepted command of the Army. Young Bonaparte, then the hero of Toulon, was pale, emaciated and haggard in appearance but his energy and endurance were amazing. Out of chaos came order and discipline in swift succession. He was beginning to realize the acuteness of his insight and the scope of his powers. But he was ailing. He was susceptible to colds and coughed perceptibly. Josephine was worried about his physical appearance from the time she first met him. When he was 30 years of age, he wrote to Josephine, "My cold is no better." This statement assumes significance only in the light of continued ill health. On his return to Paris, Josephine consulted Covisart who had been introduced to Napoleon at the home of Barras and who was to achieve wide recognition as his personal physician.

While acquiring great fame through his Italian campaign, and undergoing the most

exacting mental and physical activities his ill health persisted and his followers seemed to be inspired by his sickly appearance. According to Stendahl, "men laugh and sigh and die smiling." Sokoloff says, "During the period of the Consulate, he looked particularly ill. 'Bonaparte, the First Consul, is a man of short stature with a sad face and burning eyes. . . . His health is very poor and his skin is covered with blotches. His illness adds to his violence and activity. He sleeps three hours a night and takes no medicines, unless his suffering becomes unbearable,' writes the political agent of the Count d'Artois."

Napoleon seemed never to suspect tuberculosis but being impressed with the hereditary predisposition to cancer, he feared his son would suffer the fate he so accurately anticipated in his own person and planned to have him notified when death proved his well-founded fears. Though the message was conveyed by Dr. Antommarchi, it was never delivered to the son who died of advanced pulmonary tuberculosis (confirmed by autopsy) at the age of 21. This circumstance seems to support the belief that the symptoms of toxemia which dominated the most active period of Napoleon's career were due to tuberculosis. The persistent cough followed him through the Egyptian campaign though less annoying than during the Italian period. Periodically he suffered from chest pains and difficult breathing. At the risk of too much repetition we quote freely from Sokoloff in support of the theory that in all probability tuberculosis was among the chief motivating factors in the life of this great man.

"In 1803 at Brussels, however, Bonaparte became seriously ill from a chest congestion. He vomited and spat blood. Dr. Covisart treated him quite successfully and he recovered quickly. This may well have been an attack of pleurisy, as such an assumption would be in accordance with the post-mortem findings: '. . . in opening the thoracic cavity, we observed a slight adhesion of the left pleura to the costal pleura.' But one is also free to suspect that this attack may have been a manifestation of tuberculosis.

"There is no further mention of any serious lung disorder, until the fourth year of his exile on St. Helena, in September, 1820. There, he began to suffer once more from a dry, persistent cough.

"'What do you think of my lungs?' he asked Dr. Antommarchi. 'Will I die of a lung disease?'

"'Certainly not, sire.'" Antommarchi hastened to reply, in his characteristic, know-it-all manner.

"He was fully convinced that Napoleon's lungs were perfect. But it is all the more in-

teresting to note that the post-mortem records made by this same physician point to the presence of a tubercular process in Napoleon's lungs.

"Such are the medical facts and records. In spite of their incompleteness and sketchiness, it is hard to doubt that Bonaparte was tubercular. His persistent coughing in his younger days, his feverish appearance, his unusual emaciation — all of these might be taken as indicative of tuberculosis but would not be sufficiently conclusive to warrant such diagnosis, if it were not for the post-mortem records. These records speak of an old tubercular process, which became somewhat dormant with years. This process not being acute, the organism was able to resist it stubbornly. An apparent recovery took place. In his late thirties, Napoleon grew stouter and entirely lost his former emaciation. And only after he had spent several years on St. Helena, did he begin to cough again. Possibly this indicates that the old tubercular process was coming to life. Might it not have found its stimulus in the weak state of Napoleon's health, which was due to cancer?"

"In considering these two diseases in relation to Napoleon, it is interesting to note the striking difference they exert on the psychology of the affected man.

"A cancer patient is mentally depressed, as a rule. He is spiritually weary, although the illness itself may be only in its period of inception and the patient totally unaware of it. Even at this stage, an increase in passivity may be observed in persons who are ordinarily active. Despondence grows with the development of the disease. An undefined feeling of melancholy takes possession of the sick man; he begins to be troubled by vague thoughts of an impending doom. Then physiological changes that are taking place are reflected in the entire mental makeup of the person — he is morally depressed, hesitant, apathetic.

"An entirely different picture is presented by an individual suffering from tuberculosis. Even when his condition is hopeless, when there are but a few months left to live, he feels the urge to activity; he is replete with feverish energy; he has faith in himself, in his future, in his work. At times his bubbling activity reaches a higher level than that of a healthy, normal individual. This excessive urge to action and abnormal vitality may be ascribed to the fact that in tuberculosis a specific substance is secreted by the tubercle bacilli, which produces a stimulating effect on the endocrine system. Not only the thyroid gland, but also the adrenals are activated. As a result, the heart-regulating apparatus of tubercular patients is in a state of constant stimulation. Their temperature rises.

Their imaginations are active; at times, they even have hallucinations and see visions. Nothing seems impossible to them, nothing unattainable. They are restless, overcreative, as a result of their endocrines being overstimulated. They may become thin to the extreme.

"Might we not surmise that in the earlier days of his career, tuberculosis acted as an additional, as a secondary physiological stimulus to Napoleon's extraordinary activity. This particular period of his life, marked by superhuman energy, coincides with the manifestation of tuberculosis. His innate characteristic qualities were intensified through this factor — through the peculiar influence of the disease. His genius reached overwhelming proportions. His courage verged on sheer insanity. And his singular power of insight, almost of clairvoyance, may also have had its roots in this disease. After the tubercular process became dormant, his energy, his vitality, and even his aggressiveness declined to a certain extent.

"All that Napoleon achieved in life — his fantastic rise to success and glory — occurred during this particular period. Later years bring about a change. Errors occur, fatigue is felt. He is traveling a slow, downward path. Instead of the sickly, sallow, lean Bonaparte, harrassed by itching skin, there emerges Napoleon the Emperor, a stout, indeed, an obese man, whose skin is white and tender."

During the most active period in his career, Napoleon also suffered from scabies, frequent micturition and severe attacks of dysuria. As will be shown, the post-mortem throws light upon the latter condition. In addition, there were varied nervous manifestations involuntary twitching of muscles, shrugging of the shoulders and even periods of unconsciousness accompanying emotional upsets and over indulgence of his sexual propensities.

If we had time to pursue the case history in detail, we would record virtually all the clinical manifestations of malignancy, plus a palpable mass in the upper abdomen.

At the age of 52 Napoleon died after a period of unconsciousness, but not without a vigorous upsurging of the old spirit with sufficient strength to force Montholon to the floor with guttural cries of pain but before help arrived, the patient's strangle-hold relaxed and the indomitable Napoleon quietly yielded to the annulling influence of approaching death — the last great adversary.

Though there was much truth in Napoleon's statement, "With my body, I do all I wish," it was through the sheer force of willpower that he wrought so magnificently in the realm of physical achievement. Thus we see one of the most energetic and ag-

gressive of all men in the history of the world constantly under the influence of disease.

At St. Helena in a cheerless chamber on the plateau of Longwood, the body of the impetuous man of power lay limp and cold. Under the dim, flickering lamp of the death vigil, indistinct shadows crept across the musty room to shield the ruthless rats ready to prey upon the lifeless form of the one time proud hero. In life, ambition may lift the flesh far above all obstacles only to leave the mortal mass with the rodents when the last curtain falls.

Sokoloff presents the following authenticated report of the autopsy proceedings:

"Dr. Antommarchi, a young, easy-going and self-confident physician, attired in his white coat, scalpel in hand, begins the autopsy. It is not quite two in the afternoon — scarcely twenty hours have passed from the moment of Napoleon's death. Antommarchi, as always, is posing. He can almost see himself lecturing in an anatomical theatre, the cynosure of all eyes. Only here, instead of medical students, he is surrounded by English physicians. This circumstance stimulates his vanity. He exerts himself to exhibit his knowledge and discourses in a quasi-scientific language. It is as though he had waited for months for just this moment. One feels that this is a great day for him.

"Even he, whose body is being dissected, is forgotten for the time being. It might be the body of an unknown corporal, dead of an unknown disease. No one mentions his name. Eight surgeons are engaged in a lively medical discussion over a nameless corpse. Only the Emperor's followers, who are also present, form a strange contrast to the eager doctors. Their faces are drawn with emotion, almost with horror, at the indignity of the proceedings.

"'The body is well covered with fat. There is scarcely any hair on the skin. . . . Here is the scar of an old wound.' Opening the chest, Antommarchi continues, 'Fat is everywhere.'

"'A surcharge of fat,' puts in Dr. Henry.

"'Here the sternum is completely obscured by a layer of fat'; and measuring the thickness Antommarchi announces, 'one inch and a half. Rather strange to find this general adiposity, despite the severe and prolonged illness of the deceased.'

"'The ribs are quite difficult to cut through,' continues Antommarchi. 'Obviously the cartilages have ossified for the major part.'

"'Ordinarily this phenomenon appears much later, and for him, who was only about fifty, doesn't it seem rather premature?' remarks Dr. Rutledge.

"'Not necessarily. . . ' replies the operating surgeon and, cutting through the cartilages of the ribs, he exposes the thoracic cavity. 'Here we observe a slight adhesion of the left pleura. . . .'

"'This may be an indication of an old pleurisy,' suggests Dr. Arnott.

"'But the lungs appear to be quite sound. . . .'

"'Most likely it is just as you say,' Antommarchi agrees.

"'Well, I should say this is doubtful,' Antommarchi retorts, opening the left lung. 'Now see here; the superior lobe of the left lung is covered with tubercles. And here are numerous small tubercular cavities.'

"'This most likely represents an old process, suggests Dr. Shortt. 'At any rate, the right lung is perfectly sound.'

"'Nevertheless, the ganglia of the bronchi and of the mediastinum are enlarged.'

"'That is of little consequence.'

"'However — the state of the lungs does give an indication that he was affected.'

"'Possibly in his youth. . . .'

"'The physicians begin the examination of the heart and of the great vessels.

"'The heart and the aorta are quite normal.

"'Isn't it surprising for such an active man?'

"'But the heart is also covered by a layer of fat, observes Dr. Henry. 'And it appears to me to be of a smaller size than it should be.' Others, however, do not agree with him on that point.

"'Now let us examine the stomach.' Continuing the autopsy, Dr. Antommarchi goes on, 'At first sight, it appears to be normal.'

"'Perhaps even smaller than is usual.'

"'But now look here,' Antommarchi takes the organ in his hands; 'the anterior surface of the stomach has a slight obstruction. And here again, the left lobe of the liver is adhering closely and even rigidly to this obstruction in the stomach.' He cuts the organ open.

"'Ah! There's the cause!' exclaims Dr. Arnott, noting a dark, brownish mass which fills the cavity of the stomach. 'This looks like a scirrhus tumor. But so advanced — who would have thought it. Yet, I was right in presuming the upper part of the stomach absolutely sound.'

"'Yes, you are right,' confirms the surgeon. 'The cardia is more or less normal. But here along the lesser curvature — within the pylorus. . . . Yes, without doubt, this is a cancerous ulcer! Antommarchi pronounces with conviction. 'And do you note the deep channel that this ulcer possesses? If it were not for the adhesion to the liver which closes

this exit, this channel would have established a communication between the stomach and the abdomen!'

"'And death would have come so much sooner. . . .'

"'Without any doubt!'

"'Yet, certain portions of this ulcer appear to me to be benign.'

"'Yes, but only in spots. Here in the center, the ulcer is entirely cancerous, although the orifice of the pylorus is not touched.'

"A lively discussion grows out of the examination of the liver. The exiled Emperor's liver had given Governor Lowe some cause for alarm. The Governor was very anxious to have it shown that his prisoner did not suffer from the disease of the liver which was very prevalent on the island of St. Helena. Thus, all the more surprising seems the statement of his chief surgeon, Dr. Thomas Shortt, who remarks that in his opinion the liver looks enlarged.

"'I cannot see that at all. It is only a large liver,' protests Dr. Arnott, 'but it is no larger than the liver of any man of that age.'

"'It is certainly enlarged and diseased!' insists Dr. Shortt.

"'The liver is perfectly normal and is not enlarged at all,' retorts Dr. Burton.

"'I quite agree,' Dr. Henry puts in.

"'I repeat that this liver is enlarged,' Dr. Shortt persists.

"'But, gentlemen, you must come to some sort of an agreement. Take a close look at the liver!' remarks Admiral Reade.

"'It is normal,' five physicians reply with one voice.

"'Let me look at it,' says Reade, interrupting the dispute.

"Dr. Antommarchi takes out the liver and cuts it open with his scalpel. 'It's good,' he remarks; 'perfectly sound and has nothing remarkable in it. But, of course, it is a large liver.'

"'There is a great difference between a large liver and a liver that is enlarged,' Admiral Reade says wisely.

"'But there is a definite adhesion to the diaphragm.'

"'Well, it is of long standing. It does not indicate a recent disease.'

"'But there is no adhesion to the diaphragm at all,' points out Dr. Rutledge, a young surgeon. 'There exists only a small adhesion of the liver to the stomach.'

"'I beg your pardon, gentlemen,' interrupts Admiral Reade, impatiently. 'It seems to me that this discussion is entirely out of order. It has already been established that death was caused by a disease of the stomach.'

"Even so, the liver is in a state of disease also," Dr. Shortt insists stubbornly.

"The examination proceeds.

"Well, now! Let us consider the vesica fellis."

"The gall bladder is obviously in a sound state."

"Except that it is filled with very thick bile."

"All agree, however, that the deceased did not suffer — recently, at any rate — from cholecystitis.

"Some controversy arises once more concerning the state of the spleen. Antommarchi sees it considerably enlarged — which may be taken as an indirect indication of a reflex of hepatitis, chronic condition of the liver.

"The spleen is perfectly sound and of normal size," Dr. Arnott remarks emphatically. However, Dr. Antommarchi retains his own opinion.

"The condition of the intestines does not arouse suspicion in any of the medical men present, as the mucous membrane appears to be in a perfectly healthy state. However, on the peritoneal surface, a number of smallish specks and patches of a pale red color are noted.

"The autopsy goes on. . . .

"The kidneys are also imbedded in fat."

"May I draw your attention to this abnormality," points out Dr. Arnott, "that the left kidney is much larger than the right one?"

"So it is indeed!" They measure them. "It is fully one-third larger than the right one."

"A very unusual abnormality!"

"An acquired one."

"Scarcely," Dr. Arnott ventures, "It appears to be congenital."

"Even the left kidney seems to be out of position."

"Could not that have influenced the state of his health?"

"It is very improbable that it could."

"Considering the dead man's bladder, they all concede that it is in a diseased state. They find a number of small stones and the mucous membrane looks to be inflamed and spotted with red.

"I was certain to find his bladder inflamed!" exults Antommarchi. "During his lifetime he often complained of micturition. And here is the answer — cystitis!"

"Yes, that is how it seems to be. . . ."

"And now — now we shall start the autopsy of the brain."

"No!" protests Count Bertrand. "I consider it absolutely unnecessary!"

"But it would be so interesting," implores Antommarchi, "from the scientific point of

view!"

"We cannot allow you to touch the head of His Majesty." Montholon pauses for a moment and then continues with emotion, "It is enough that His Majesty's whole body has been mutilated!"

"I consider the autopsy as finished!" Bertrand announces firmly.

"Peculiar. . . ." Antommarchi shrugs his shoulders.

"But Admiral Reade agrees with Bertrand. 'The cause of death having been established, I do not therefore see any necessity for a further examination.'

"St. Denis, a valet, brings in two silver boxes. Dr. Rutledge removes the heart from the body and places it in a round silver box. He fills it with brandy and seals it. The stomach is placed in a silver pepperbox. This is done in accordance with the wishes of the late Emperor, who insisted that his heart be sent to his wife, Marie Louise, and his stomach to his son, in order that the latter might learn of the illness which brought about his father's death. Admiral Reade, however, declares to Count Bertrand that according to the instructions which he has received, he cannot allow the heart to be sent to Europe. Only the stomach may be sent. The refusal incenses Bertrand and Montholon, who voice protest — but vainly — against the Governor's decision.

"While this discussion is going on, Antommarchi puts the body in order. Dr. Henry assists him. Rearranged and sewed together, it suddenly ceases to be a nameless corpse and becomes once more the body of the Emperor. Peering into the face of the deceased, as if noticing it only now, Dr. Henry remarks thoughtfully:

"What a wonderfully peaceful expression! It seems to portray a disposition of mildness and sweetness. It is in striking contrast to his actual life and character." He draws Dr. Antommarchi's attention to certain peculiarities of the body, which in some respects is almost feminine in appearance. "Isn't it rather strange — for a great military commander?"

"It is almost four o'clock. The autopsy is finished."

1. Napoleon, A Doctor's Biography. Boris Sokoloff, M.D., Prentice-Hall, Inc., New York. 1937.

Duty and Doctor Synonymous

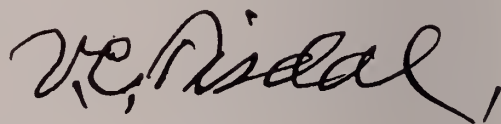
So nigh is grandeur to our dust,
So near is God to man,
When duty whispers low, *Thou must,*
The youth replies, *I can.*

—Ralph Waldo Emerson. *Pack Up Your Troubles*, p. 180.


THE PRESIDENT'S PAGE

The month of June has been an inspirational month for the officers of the State Association in carrying the program of the Association for the year to the different areas of the State. The receptive attitude and cooperative spirit manifested by the localities visited was appreciated by the speakers. The speakers have been most cooperative in giving of their time to make the long trips and they have been very happy over the response received from the doctors. The meeting in my District, Hobart, promises a revival of interest among the doctors of Western Oklahoma. There is an outstanding corps of speakers on the program and we cannot express our appreciation for this cooperation.

Another history-making event for our State was the appointment of the Board of Health by the Governor last Friday, June 15; and in his appointment he emphasized the fact that he deemed this Board the most important of boards appointed during his administration in that they had the responsibility of carrying the health program to the people of the State through the Commissioner of Health by laying a policy and program for sanitation, preventive medicine and the elevation of the acute ills, welding together a closer cooperative effort on the part of the Health Department, the Medical Association or doctors of the State, and the lay group. The educational program which, of necessity, must be carried on should have the united support of every person interested in the health and wealth of our commonwealth. It has been shown that for every soldier killed in battle, there were 17 people died from disease that should be prevented. With this challenge it behooves the State Association, the Health Department and the people of the State to work in one common front; if possible more skillfully operated and commanded than the leading of the armies by our generals in this world's conflict.




President.



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EDITORIALS

HUMANISM VS. MATERIALISM

Humanism disregards costs where necessary to enhance values. Materialism stresses costs at the expense of values. Medicine as practiced in the United States today belongs to humanism. It strives to give good individual medical care regardless of the patient's economic or social position. Medicine as proposed in the Wagner Bill, when well understood, becomes rank materialism. The people to whom it appeals cannot see that in the end it will replace the sympathetic service of humanism with the cold impersonal service of materialism.

It is the doctors' duty to enlighten the public and to bring about an equitable consideration of values. If, in spite of this, the temper of the people turns toward regimented medicine, they must suffer the sad distemper thus entailed.

THE WAGES OF WAR

There is no way to accurately estimate the cost of war. After taking into account the cost of preparation for and maintenance of a world conflict and the devastation of war-torn countries plus the loss of life through warfare, famine and disease, we must con-

sider the frightful potentialities inherent in lowered resistance. Leaving out of account other diseases which follow in the wake of war, we find that tuberculosis presents a serious threat to Germany and the liberated European countries. It is well known that the tubercle bacillus thrives in a soil prepared by starvation, physical strain, mental anguish and exposure to other unfavorable conditions. As early as 1942 it was estimated that, during the German occupation, deaths from tuberculosis in Paris had increased 40 per cent. Though reports from Germany and other occupied European countries were fragmentary they indicated that conditions were disastrous and that tuberculosis was rampant. Now that Germany has fallen and the occupied countries have been liberated, the truth, so long crushed to earth, is rising with shocking revelations.

While comprehensive diagnostic studies are wanting recent routine examinations of the men still living in some of the German prison camps when our armies arrived on the scene, showed the incidence of active tuberculosis to be as high as 40 to 60 per cent. Considering the hardships suffered by the millions of dislocated people throughout war-

torn Europe today, it is reasonable to believe a routine study with reference to the incidence of active tuberculosis would show that the gain achieved in three generations has been completely wiped out and it is safe to say that the upward trend in incidence and mortality is beyond immediate control.

Though the United States has not felt the heavy hand of local combat, the people have had to meet serious population dislocations in certain centers of war industry, often resulting in overcrowding, poor housing, night work, over-time, etc., with all the anxiety throughout the nation entailed by war. In spite of all this the high level of our national health and the continued low mortality rate from tuberculosis stand as a monument to over-worked civilian doctors improved preventive measures, and the mounting stamina of our national stock. Nevertheless, we must be vigilant.

MEDICAL CARE HOW PERSONAL, HOW SACRED

Oklahoma is proud of her sons now serving humanity throughout the world. Particularly are we proud of our home made medical men who have carried to allied fighting men throughout the world the best military medicine ever placed on record. The University of Oklahoma School of Medicine may well afford to treasure its part in the war.

The following paragraphs from a letter¹ addressed to the mother of our own Oscar W. (Bill) Stewart² are worthy of editorial notice for many reasons, but most of all because they reveal a layman's impression of the intimate personal patient-doctor relationship which must never be lost and the fine tradition which medicine must guard with its life. After an urgent appeal to the recipient of this letter we secured permission to quote. We do so with profound apologies to the modest, retiring young neuro-surgeon.

"I want to tell you how much both my husband and I feel we owe to your wonderful son, Colonel Stewart. Our two boys have been under his care when they were returned wounded from the Front.

"Our younger boy was seriously wounded when the Airfields in Holland were attacked early in January. It is a miracle that we still have him, and we feel we owe more than words can say to all that Colonel Stewart did for him when he was brought back in a plane from the Field Hospital. It was the most delicate head operation, and it was superbly done.

"You can, therefore, imagine we have a very special feeling for those in charge of the Neurological Hospital at Basingstoke!

"From the very beginning there has been

a very wonderful atmosphere in that hospital in all it does. It follows in the fine tradition of those we have always admired so much, and who were great friends of ours — Osler, Cushing, then Bottrell, and now your son, whom we admire more than I can tell you, besides having a great affection for him.

"He was so charming one day when he told us about the honor that your State had conferred on you. He has told us of the wonderful work which you and your husband inaugurated, and which you are now carrying on so nobly.

"Anything connected with the blind touches us very much, as our second son, Hart, on whom Colonel Stewart had to perform the operation, had his sight saved years ago by Harvey Cushing, in Boston.

"Forgive this rather incoherent letter, but I felt I must write and tell you how full of gratitude our hearts are for all your son has done for us and how full of admiration we are for him."

1. Letter from Mrs. Alice Vincent Massey, Canada House, Trafalgar Square, London, S. W. 1.

2. Oscar W. Stewart, M.D., graduate of Oklahoma University School of Medicine, 1934.

NAPOLEONIC MEDICAL LEGISLATION

Though Napoleon was not a good patient, he was a worthy patron of medicine. At the turn of the Century following the French Revolution, clinico-pathological studies were initiating a new era in clinical medicine. Chief among the exponents of this remarkable movement in France were Bayle, Bichat, Laennec, Louis and Napoleon's own personal physician, Covisart.

The practical application of scientific knowledge was not limited to medicine. Material prosperity and political power placed extra demands upon industry for increased comforts. Thus, chemistry was beginning to find its place in industry. Jean Antoine Chaptal, M.D., who taught chemistry at Montpellier, and whose researches were devoted to manufacturing and industry, was appointed Minister of the Interior by Napoleon.

In 1801 the chemist and physician, Antoine Francois Fourcroy joined the Minister and other chemists in the formation of a National Society to encourage industry. Already Napoleon had offered a prize of 60,000 francs for researches and inventions in the field of electricity. To further illustrate Bonaparte's interest in things scientific and their material significance, we call attention to the fact that on his Egyptian campaign he took with him not only engineers, but chemists, mineralogists, zoologists, botanists, astronomers and physicists. His object being the scientific industrialization of Egypt for the benefit of France.

With these facts in mind it is not surprising that under the direction of the chemist-physician Fourcroy, Napoleon was anxious to forward the health of France through suitable legislation. In 1803 a law bearing his name was designed to govern the practice of medicine in France. It provided rigid examinations for medical and surgical students and the newly-created health officers. It required four years study in recognized medical schools with exacting examinations before they were ready for the practice of medicine, surgery or public health. The law also provided for the training and appointment of midwives and established penalties for infractions of its provisions. A governmental decree in the same year provided for the erection of medical schools at Turin and Mainz. In this connection, Naumann¹ says:

"More interesting than the many purely administrative stipulations are, however, the regulations for the medical examinations since they give an exact idea of the training which was then required of young internists and surgeons. During the examinations in the more strictly medical subjects, care was to be taken to test thoroughly not only the candidate's theoretical knowledge but also his practical ability. The candidates had to prepare anatomical specimens and several medicaments, and to carry out examinations and operations at the bedside before being permitted to take the theoretical examinations and to defend their theses. Of interest also are the regulations dealing with the fees at the state medical schools. The admission fees varied between 100 and 140 francs per annum, the examination fees increased successively from 60 francs for the first examination to 120 francs for the final disputation. In general, however, the costs were considerably lower than they had formerly been, in line with the general tendency of the law to make the study of medicine available to as many classes of the population as possible."

In connection with the government controlled medical schools, apothecaries schools were established with correspondingly high standards. Finally it was incumbent upon the apothecary and medical schools to examine the herb dealers in order to determine their qualifications and to insure safe preparation, handling and preservation of their commodities.

Again we quote freely from Naumann²:

"During 1808-1810 Napoleonic legislation also intervened with a number of imperial decrees in the medical courses of the universities in the conquered countries, especially in Italy. In its sections dealing with medicine, the Code Napoleon, issued in 1806, oc-

cupies itself chiefly with questions of civil law arising out of medical practice. The criminal code of 1800 established penalties for issuing false certificates of health, abortion, infractions of medical secrecy, and for dispensing spoiled drugs. This latter category included apothecaries as well as physicians.

"Among the hygienic measures of a general nature which were instituted under Napoleon's regime the following may be mentioned briefly here: the regulations contained in the Code Napoleon and in several decrees concerning the construction of wells and the purity of drinking water; the decree issued on October 15, 1810, regarding the erection of factories and workshops which spread unhealthy or evil odours; regulations dealing with burials and the laying out of new graveyards; the detailed regulations concerning disinfection with mineral acids to prevent the spread of contagious diseases (Decree of April 18, 1812); prohibition of the sale of patent medicines which had not been expressly approved by a commission appointed by the ministry. The general aims set up for this commission on August 18, 1810, remind one of recent legislation. The commission was to determine: 1) the components of the remedy and whether its action might not be harmful or dangerous in certain cases, 2) whether the remedy was of any value and actually produced the promised therapeutic action, 3) the price which the discoverer deserved for his achievement. Special attention was paid to smallpox vaccination. An imperial decree dated March 16, 1809, concerned itself with vaccination. It provided for the erection of 25 depots in France where the vaccine could be constantly stored, and provided an annual sum of 100,000 francs for the promotion of vaccination. Each year prizes in the sum of 3,000, 2,000 and 1,000 francs were offered and 100 silver medals with the image of the Emperor were provided for those physicians whose services in the cause of vaccination had been especially meritorious. The following figures give some idea of the number of persons vaccinated in Paris during the Napoleonic period: 1808—368,405; 1809—269,367; 1810—510,953."

Regardless of what the world may think of Napoleon, conquerer and Emperor, we must acknowledge a debt of gratitude for what he did toward the advancement of medical science and its application to human needs.

1. W. Naumann, M.D.; *Napoleon's Medical Legislation*. Ciba Symposia, Vol. 3, No. 6, pp 991-992. September, 1941.

2. W. Naumann, M.D.; *Napoleon's Medical Legislation*. Ciba Symposia, Vol. 3, No. 6, p. 992. September.

Pregnancy Needed Weight-Gain, and Proteins

One of the tasks imposed upon the gravid organism is to produce new tissue to the extent of almost one-fifth of its own normal body weight.* Unless protein supply in the diet is adequate, quantitatively as well as biologically, the hazard for the maternal organism increases and the development of the fetus may be impaired. The proteins of meat are of the right kind not only to lay down these new tissues, but also to provide for the stepped-up functions during pregnancy, for which proteins are essential.

* "During pregnancy the average normal woman gains approximately 18-22 pounds, which represents the growth of the uterus, breasts and other organs as well as the fetus and placenta. In other words, a pregnant woman in nine months reproduces tissue almost equivalent to one-fifth of her own normal body weight. It must not be forgotten that the chief function of protein is to supply the tissue-building material of the body, that the need for this material is increased during pregnancy and that the protein deficiency in the diet of the nonpregnant woman may become dangerous when maternity intervenes. . . . It is reasonable to assume that protein foods satisfy appetite earlier than the others and make it content with fewer calories. In this respect we have found high protein diets of value for weight restriction during pregnancy." (Arnell, R. E.; Guerriero, W. F.; Goldman, D. W.; Huckeby, E., and Lutz, A. M.: PROTEIN MALNUTRITION IN PREGNANCY, New Orleans M. & S. J. 95:114 [Sept.] 1942).



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ASSOCIATION ACTIVITIES

STATE BOARD OF HEALTH APPOINTED BY GOVERNOR KERR

On Saturday, June 16, Governor Robert S. Kerr appointed the State Board of Health as provided by the past Legislature. Governor Kerr appointed five medical doctors, an osteopath, a dentist, an administrator and an engineer of the Board who will assume their duties on July 1. Governor Kerr said:

"The responsibility of making a success of the health program will be in this Board. I selected a representative of the dentists, the osteopaths, the sanitary engineers, a hospital administrator and five outstanding physicians and surgeons. All of them are enthusiastic for the health program, an opportunity to put into effect and to take it to the people of the State.

"Representatives of the federal health service, Major General George F. Lull, deputy surgeon general of the U. S. Army, and members of the Oklahoma State Medical Association have been outspoken in commendation of the health program of the legislature. Some of them said it was the best advanced by any State."

The law required appointment of a majority of the Board to be medical doctors and members of the Oklahoma State Medical Association. It also required appointment of eight of the members by congressional districts.

The appointments are as follows:

- At Large—C. R. Rountree, M.D., Oklahoma City, Chm.
- First District—Dr. A. G. Reed, Osteopath, Tulsa.
- Second District—Charles Ed White, M.D., Muskogee.
- Third District—T. H. McCarley, M.D., McAlester.
- Fourth District—Catherine Brydia, M.D., Ada.
- Fifth District—Mr. R. L. Loy, Hospital Administrator of Oklahoma City General Hospital, Oklahoma City.
- Sixth District—Mr. William F. Schumacher, Engineer, Lawton.
- Seventh District—V. C. Tisdal, M.D., Elk City, President of the Association.
- Eighth District—Fred Seids, D.D.S., Perry.

DELEGATION FROM ASSOCIATION HAS PROGRAM FOR CREEK COUNTY MEDICAL SOCIETY

On June 12, the Delegation of Speakers from the Oklahoma State Medical Association were asked to conduct the meeting of the Creek County Medical Society in Bristow. There were 15 physicians present, this meeting being the last one until next fall.

The program was in charge of Dr. Philip Joseph, Sapulpa, Secretary of the Society, who called the meeting to order and turned it over to Dr. V. C. Tisdal, President of the Association. Dr. Tisdal explained the Four-Point Program of the Association and the establishment of the Speaker's Bureau for the use of the County Societies. He stated that the service given by the Association was for the people as well as for the doctors.

Dr. J. T. Bell of the State Health Department explained the F.M.I.C. program. Dr. Bell explained that the purpose of the plan was to provide complete medical care for the wives and infant care for the babies up to one year of age for the men in the armed forces in the lower four pay grades. Statistics were then given, outlining the number of applications received for this benefit, the number hospitalized and the number of infants treated. A detailed outline of the plan was given as to allowances for pre-natal care, post-partum care and infant care.

Dr. Tisdal then introduced Dr. Edward N. Smith of Oklahoma City who spoke to the physicians on the subject of maternity mortality. Dr. Smith discussed the abuse of the Caesarian section, declaring that while the operation may be the easiest and quickest way for the doctor, it is not the safest way for the patient. Dr. Smith explained the use of questionnaires in determining the exact causes of the deaths caused by child birth, and the steps being taken to prevent them.

Dr. C. R. Rountree, Oklahoma City was then called upon to speak on the responsibility of the State Association to the County Society. Dr. Rountree explained that the individual physician was in control and through his wishes and desires, the County Society, the Association and the American Medical Association functioned for the benefit of the entire profession. He urged that each doctor take steps to be a Fellow in the A.M.A., and to subscribe to the Journal of the A.M.A., as through its pages came the latest developments in the medical world both scientific and political. He said that it was the duty of the State Association to keep each doctor informed of the activities of the Association and the medical legislation; discussing the Wagner Bill in its new form, S 1050. He emphasized the fact that the doctors themselves governed the Association through the Council and House of Delegates and that through their suggestions and criticisms, the Association would be in a position to better serve them.

Dr. Tisdal then told the physicians of the legislation passed in the last legislature and expressed appreciation of the help of the Hon. Fletcher Johnson, Bristow, in the passing of the health bills. He also expressed the appreciation of the Association to Dr. O. W. Starr, Drumright, Representative, for his help in these matters.

Mr. Paul Fesler, Executive Secretary, was then introduced and explained the health legislation in detail. Mr. Fesler explained the anticipated hospital survey and told of the situation in the state relative to hospital beds and the establishing of health centers over the state with a control at the University Hospital in Oklahoma City. He explained the medical school appropriation and the expansion program being worked out by Dean Tom Lowry with regard to physical plant enlargement and the establishing of training courses.

Dr. James Stevenson, Tulsa, was next introduced and spoke on the Blue Cross Plan and the Prepaid Surgical and Obstetrical Care Plan. Dr. Stevenson explained that the sole purpose of these plans was to help the people in the event of catastrophic illness. He outlined in detail the benefits covered by both plans and explained that the Prepaid Medical and Obstetrical Care Plan could be put in operation only through the request of the County Society.

Dr. Richard M. Burke, Oklahoma City, was next called upon to tell the physicians of the program of tuberculosis being carried over the State. Dr. Burke explained that the principle effort was to locate the contacts of the disease. He said that portable x-ray units were being taken all over the state for the purpose of obtaining an x-ray of the lungs of every person. He stated that many cases had been uncovered in this manner and that each year, through this process, the death rate was being lowered. Dr. Burke explained the need of hospital beds and gave credit to the Association and the Legislature in the passing of the bills in the last Legislature regarding this condition.

Dr. Ralph McGill, Tulsa, was next given the floor and discussed the Cancer Committee activities. He explained that the cancer control was the doctors program and urged a wide spread educational program. Dr. McGill said that the Cancer Drive was very successful and the

amount raised had gone over \$100,000.00. He then explained the ideas advanced for the expenditure of the funds.

Dr. Tisdal then explained, more in detail, the program of the Association (previously printed) and enlisted the doctor's support. He expressed the appreciation of the County Society's invitation to the delegation to conduct the meeting.

SCHOOL OF MEDICINE COMMENCEMENT GALA OCCASION

On Friday, June 15, commencement exercises were held for 72 doctors and 38 nurses of the Oklahoma University School of Medicine at the Municipal Auditorium in Oklahoma City.

The ceremony was beautifully conducted and most effective. The procession was conducted by the U. S. Navy, V 12, N.R.O.T.C. Band after which was the presentation of colors by the Navy Color Guard. The National Anthem was sung and then the invocation was given by Reverend John Abernathy, pastor of the Crown Heights Methodist Church.

Hon Robert S. Kerr, Governor of the State was introduced and gave a short opening talk. The Commencement Address was then given by Major General George F. Lull, Deputy Surgeon General of the U. S. Army.

General Lull's topic was "Medical Department of the U. S. Army." He explained what the medical department is and what it does, also what the medical doctor will do when he enters the army. He further explained the care exercised by the Army in selection of its men. The responsibilities of a doctor in the army were given as the care and evacuation of the injured, dental care, dietary care and the knowledge and care of medical supplies. Good training of doctors, prompt treatment given the wounded and newer methods of treatment were some of the reasons given for the reduction of the death rate in World War II. General Lull described the evacuation of wounded soldiers and the care given on the beachhead of Normandy. He stressed the fact that after the war, public health will be better because doctors will have gained from their military experiences. He said "the American soldier is getting better care than any soldier in any army in any war up to the present."

Dean Tom Lowry, M.D., Class of 1916, presented the candidates for the Degree of Doctor of Medicine and George L. Cross, Ph.D., President of the University of Oklahoma conferred the degrees. Dr. L. J. Starry, Faculty of the School of Medicine introduced the class members. Dean Lowry then presented the candidates for diploma of graduate nurse and Dr. Cross conferred the degrees. Mrs. Calara W. Jones of the School of Nursing of the University introduced the class members.

Captain George E. Richardson, Commanding Officer, A.S.T.U. No. 3865 awarded commissions for the Army of the United States and executed the Oath of Office

to those going into the Army. Lt. William T. Lace, U.S.N.R., Liaison Officer, Navy V-12, presented the candidates for Navy Commission and the commissions and Oath were delivered by Captain Erasmus W. Armentrout, Jr., U. S. Navy.

Major General Raymond S. McLain of Oklahoma City was introduced and said a few words. Dr. J. W. Finch, Hobart, Class of '31, President of the Alumni Association welcomed the Class of '45 to membership in the Alumni Association of the School of Medicine, which welcome was accepted by Dick Moss Lowry, President of the Class.

PAUL H. FESLER APPOINTED HOSPITAL ADMINISTRATOR

Mr. Paul H. Fesler, Executive Secretary of the Oklahoma State Medical Association has been appointed as Hospital Administrator at the University Hospital in Oklahoma City. Mr. Fesler will carry on, part time, as Executive Secretary of the Association until a suitable successor is obtained.

Mr. Fesler is nationally known in Hospital work and is a past president of the American Hospital Association. He came to Oklahoma City from Nopeming, Minnesota where he was General Manager of the Nopeming Sanatorium.

DR. A. W. PIGFORD ON ROAD TO RECOVERY

Dr. A. W. Pigford, Tulsa, has been seriously ill at Hillcrest Hospital in Tulsa for the past several weeks. Dr. Pigford's condition is reported as improved.

MAJOR GENERAL LULL GUEST SPEAKER AT COMMENCEMENT

Major General George F. Lull, Deputy Surgeon General of the United States Army, arrived in Oklahoma City on Friday, June 15 to speak to the graduates of the Oklahoma University School of Medicine. Brig. Gen. W. Lee Hart, Medical Director of the Eighth Service Command for the past five years, arrived from Dallas to attend the commencement.

The generals made an inspection visit to the University of Oklahoma School of Medicine in the morning, after which a luncheon was given in their honor by the Oklahoma County Medical Society at the Skirvin Hotel. The Oklahoma City Chamber of Commerce were hosts at a dinner preceding the commencement exercises.

General Lull, whose army experience covers 33 years, commanded a base hospital in France in World War I. He also served in the army of occupation in Germany, in the uprising at Yangtze, China and the Mexican border. For the past five years he has served at Chief of Personnel Service of the Surgeon General's office before being assigned to his present post.

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*Edward Allphin Allgood	Altus	Harris Memorial Methodist Hospital, Ft. Worth, Texas
†Cad Walder Arrendell, Jr.	Ponca City	Naval Hospital, Norman, Oklahoma
*Broadway Broadrick	Chickasha	Methodist Hospital, Dallas, Texas
†J. T. Brooks	Marlow	Navy Hospital, Shoemaker, California
Sue Elizabeth Browder	Woodward	Boston City Hospital, Boston, Mass.
*Arthur Merton Brown, Jr.	Muskogee	Hillcrest Memorial Hospital, Tulsa, Okla.
*DeLon Nello Brown	Oklahoma City	U. S. Marine Hospital, Baltimore, Md.
*Irwin Hubert Brown	Oklahoma City	St. Joseph's Hospital, Milwaukee, Wis.
*Leonard Harold Brown	Oklahoma City	Boston City Hospital, Boston, Mass.
*Richard Herbert Burgtorf	Custer	University Hospital, Oklahoma City, Okla.
Martha Jene Burke	Oklahoma City	Crawford W. Long Memorial Hospital, Atlanta, Ga.
*Robert Elsworth Casey	Oklahoma City	Cook County Hospital, Chicago, Ill.
*Stanley Gray Childers	Tipton	Good Samaritan Hospital, Portland, Ore.
*Marvin Allen Childress	Allen	University Hospital, Oklahoma City, Okla.
†James William Clopton	Oklahoma City	University Hospital, Oklahoma City, Okla.
†Charles Stewart Cunningham	Henryetta	Navy Hospital, Norman, Okla.
*Walter Traynor Dardis, Jr.	Oklahoma City	Good Samaritan Hospital, Portland, Ore.
*Robert Pinkerton Dennis	Oklahoma City	Wesley Hospital, Oklahoma City, Okla.
*Walter Henry Dersch, Jr.	Oklahoma City	Methodist Hospital, Memphis, Tenn.
*John Woodrow DeVore	Elk City	Baltimore City Hospital, Baltimore, Md.
†Cecil Homer Dillingham, Jr.	Frederick	Navy Hospital, Bainbridge, Md.
*Loren Alonzo Duntun	Miami, Florida	Miami General Hospital, Miami, Florida
†Martin Dale Edwards	Cameron	Navy Hospital, San Diego, Calif.
†Arthur Furman Elliott	Enid	Navy Hospital, Great Lakes, Ill.
*Richard Allison Ellis	Duncan	Ohio State Hospital, Columbus, Ohio
*James Burnette Eskridge, III	Oklahoma City	Jersey City Medical Center, Jersey City, N. J.
*Charles Louis Freede	Oklahoma City	Hurley Hospital, Flint, Mich.
†Jack Birden Garlin	Bartlesville	Navy Hospital, Norman, Okla.
Dorothy Elizabeth Gore	Blanchard	
Benjamin Franklin Gorrell	Tulsa	Creighton Memorial St. Joseph's Hospital, Omaha, Nebr.
†Jack L. Gregston	Marlow	Navy Hospital, Norman, Okla.
*Orville Lee Grigsby	Spiro	St. John's Hospital, Tulsa, Okla.
*Arthur Edward Hale	Alva	Columbus State Hospital, Columbus, Ohio
*Richard Lowel Harris	Oklahoma City	Wesley Hospital, Oklahoma City, Okla.
*Marvin Bryant Hays	Vinita	University Hospital, Oklahoma City, Okla.
*James Thomas Hearin	Arkadelphia	Queen's Hospital, Honolulu, Hawaii
*Richard Guy Hobgood	Concho	Emanuel Hospital, Portland, Ore.
*Richard Davis Hoover	Oklahoma City	University Hospital, Baltimore, Md.
*Paul Kouri	Granite	Wesley Hospital, Oklahoma City, Okla.
*William Penn Lerblance, Jr.	Checotah	University Hospital, Oklahoma City, Okla.
†Dave Bernard Lhevine	Tulsa	Navy Hospital, Brooklyn, New York
*Dick Moss Lowry	Oklahoma City	St. Anthony Hospital, Oklahoma City, Okla.
*Charles Robert Mathews	Oklahoma City	St. Mary's Hospital, Rochester, N. Y.
†Dalton Blue McInnis	Muskogee	Navy Hospital, Long Island, N. Y.
*Vernon Conrad Merrifield	Norman	St. Anthony Hospital, Oklahoma City, Okla.
*Raymond Delbert Niles Miller	Hollis	Indianapolis City Hospital, Indianapolis, Ind.
*Walter Mason Moore	Muskogee	Missouri Baptist Hospital, St. Louis, Missouri
†Elmer Grant Murphy	Stillwater	Navy Hospital, Bethesda, Md.
Paul Joseph Ottis	Okarehe	St. Anthony Hospital, Oklahoma City, Okla.
*William Raymond Paschal	Oklahoma City	University Hospital, Oklahoma City, Okla.
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*Henry Clinton Smith	Lawton	St. Mary's Hospital, Detroit, Michigan
†Newton Converse Smith	Cherokee	Navy Hospital, Camp LeJeune, N. C.
*Walter Fred Speakman	Drumright	University Hospital, Oklahoma City, Okla.
*Gerald Matthew Steelman	Hearldton	University Hospital, Oklahoma City, Okla.
William Harrison Stover	Syracuse, N. Y.	St. Joseph's Hospital, Milwaukee, Wis.
*Glenn Vernon Sundquist	Mitchell, S. D.	Milwaukee County Hospital, Milwaukee, Wis.
*Byron Webster Tatlow, Jr.	Oklahoma City	Hurley Hospital, Flint, Michigan
*James Harold Tisdal	Elk City	University Hospital, Oklahoma City, Okla.
Clyde Edward Tomlin	Kingfisher	State of Wisconsin State Gen. Hospital, Madison, Wis.
*Howard Grafflin Tozer	Oklahoma City	University Hospital, Oklahoma City, Okla.
*Milford Shael Ungerman	Apache	Hillcrest Memorial Hospital, Tulsa, Okla.
*Cecil Ray Waterbury	Apache	University Hospital, Oklahoma City, Okla.
†James Riley Winterringer	Stillwater	Navy Hospital, Bainbridge, Md.

(†)—Commissioned at Lieutenant (jg) Medical Corps, U. S. Naval Reserve.

(*)—Commissioned First Lieutenant, Medical Corps, Army of the United States.

NURSES

Fern Adams	Payson, Okla.
Frances Bailey	Altus, Okla.
Vera Barnard	Okmulgee, Okla.
Alberta Blount	Seiling, Okla.
Mayon Bush	Wetumka, Okla.
Jeanne Crawford	Vinita, Okla.
Virginia Dees	Healdton, Okla.
Margaret Dewar	Roger, Okla.
Eva Dean Dick	Vinita, Okla.
Natalie Evans	Pauls Valley, Okla.
Sarah Ferguson	Stillwater, Okla.
Anna Raye Hogue	Purcell, Okla.
Georgia Holland	Chester, Okla.
Frances Hyde	Ponca City, Okla.
Lena Jantz	Moore, Okla.
Doris Marie Jay	Beatrice, Nebraska
Sibyl Lane	Holdenville, Okla.
Clara Long	Asher, Okla.
Barbara Macklin	Oklahoma City, Okla.
Virginia Morris	Prague, Okla.
Marguerite O'Neil	Holdenville, Okla.
Frauces O'Neil	Seminole, Okla.
Nadine Peck	Leedey, Okla.
Jean Priebe	Okeene, Okla.
Mary Lee Reeves	Disney, Okla.
Betty Studer	Canadian, Texas
Thelma Thiessen	Hydro, Okla.
Clara Washington	Meeker, Okla.
Beth Wheeler	Hatfield, Arkansas
Joy Ann Wiley	Chickasha, Okla.
Kathleen Wilkins	Walters, Okla.
Muriel Wood	Tompae, California
Charleue Ziegler	Prague, Okla.

Requiem

Under the wide and starry sky,
Dig the grave and let me lie.
Glad did I live and gladly die,
And I laid me down with a will.
This be the verse you grave for me:
Here he lies where he longed to be;
Home is the sailor, home from sea,
And the hunter home from the hill.

—Robert Louis Stevenson. *A Physician's Anthology of English and American Poetry*, p. 331.

RADIUM

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FOR ALL MEDICAL PURPOSES

Est. 1919

Quincy X-Ray and Radium Laboratories
(Owned and directed by a Physician-
Radiologist)

HAROLD SWANBERG, B.S., M.D., Director
W.C.U. Bldg. Quincy, Illinois



DOCTOR, MEET THE DARICRAFT BABY

Perhaps you are "meeting" the Daricraft Baby every day in your own practice. If not, may we call to your attention the following significant points of interest about Vitamin D increased Daricraft:



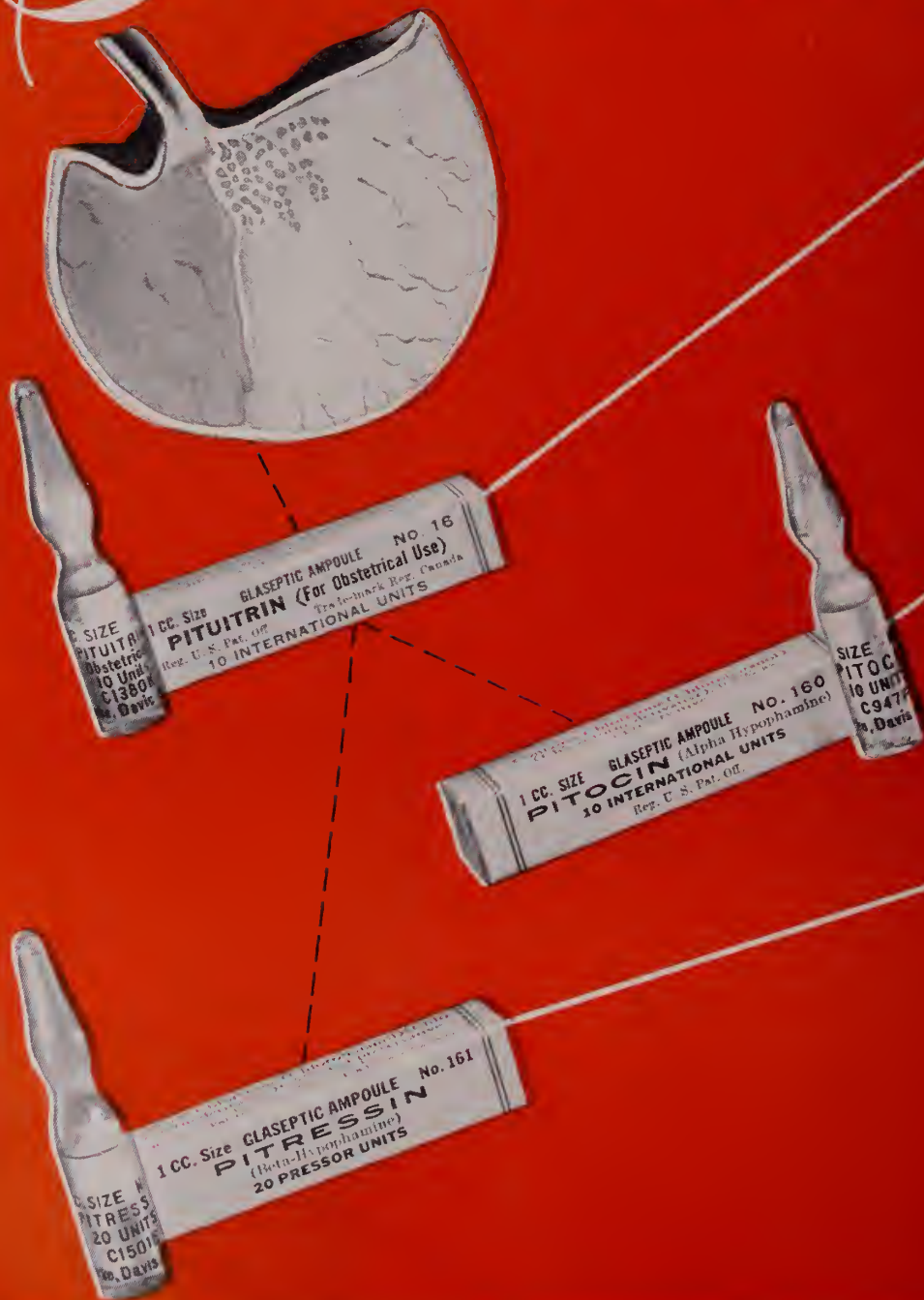
1. Produced from inspected herds;
2. Clarified;
3. Homogenized;
4. Sterilized;
5. Specially Processed;
6. Easily Digested;
7. High in Food Value;
8. Improved Flavor;
9. Uniform;
10. Dependable Source of Supply.

Producers Creamery Co.
Springfield, Mo.



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for pressor and oxytocic effects

★ PITUITRIN

Original aqueous extract of the posterior lobe of the pituitary gland developed in the Research Laboratories of Parke, Davis & Company. It contains both the pressor and oxytocic factors and is widely used in surgery and obstetrics.

for oxytocic effect

★ PITOCIN

(alphahypophamine)

Aqueous extract of the posterior lobe of the pituitary gland containing the oxytocic principle, but is relatively free from the pressor and antidiuretic principles. Indicated in cases in which stimulation of the uterine musculature solely is desired.

for pressor and antidiuretic effects

★ PITRESSIN

(betahypophamine)

Aqueous extract of the posterior lobe of the pituitary gland containing the pressor and antidiuretic principles, but is substantially free of the oxytocic principle. Indicated in the control of diabetes insipidus, increasing the muscular activity of the bladder and intestinal tract, and to raise the blood pressure.

Parke, Davis & Company

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FIGHTIN' TALK



MAJOR W. A. HOWARD, Chelsea, is to be discharged from the Armed Forces on July 1 and will resume private practice at Chelsea. Dr. Howard served in World War I and was a Major in the Reserve Medical Corps. He has served in World War II since February, 1943. *Welcome back, Major.*

The following interesting letter was recently received from CAPTAIN JOHN MOGAB, Enid:

"Our mission has been as a holding unit for the Evacuation of casualties. Back in France and Luxembourg we sent out the patients by hospital train but after we reached Germany, all our patients were evacuated by air. During the last days of the war, a large proportion of our patients consisted of liberated prisoners of war. Our own American boys had been prisoners from four months (Battle of the Bulge) to two years (Air Corps bombing personnel). One of our moves was by air from Trier, Germany to a point about midway between Frankfurt and Kassel. It was my first plane ride and I enjoyed it a great deal.

"On several occasions we found ourselves ahead of the Evac hospitals from which we got our patients, and once or twice, we set up on airstrips in areas through which only the tanks had been and the infantry hadn't yet arrived for their mop-up.

"I didn't see anybody get very excited over V-E day here; there's too much realization of the job yet ahead in the Pacific.

"I've run into only a couple of Oklahoma M.C.s since I've been overseas: MAJOR BRUCE HINSON, from my home town of Enid, and TOM McMULLEN who graduated with me back in May, 1943. Major Hinson is with an auxiliary surgical group and Tom is with a Field Hospital.

"Got a promotion April 1, we were moving so fast and so far in those days that it was mid-April before it caught up with me.

"Right now, we're all 'sweating out' our new fate—

"Congratulations to all of you for your efforts on the recently passed medical legislation in Oklahoma; we 'over here' appreciate it."

CAPTAIN ROBERT L. KENDALL, Ardmore, now serving in Germany has been awarded the Bronze Star medal. The citation accompanying the medal said: "For meritorious service in direct support of combat operations from Aug. 15, 1944, to Jan. 15, 1945, in France. During this period Captain Kendall's station has operated under a variety of conditions ranging from rapid advances requiring a high degree of mobility to static conditions with a large number of casualties. Despite adverse circumstances, Captain Kendall obtained a high state of efficiency and standard of medical care. The problem of serving two additional regiments was handled promptly and efficiently under his direction."



POISON IVY EXTRACT



for Prophylaxis and Treatment



A dilute alcoholic non-nodule forming Extract of Poison Ivy.

Tolerance to the toxic principle of poison ivy can be increased by administration of proper doses of its extract.

Prophylaxis: It is wise to start treatment 2 or 3 weeks before expected exposure. A series of at least three doses administered at 4-7 day intervals is recommended.

Treatment: In mild cases one dose is sufficient. In more severe cases 2 or 3 doses administered at 24 hour intervals may be necessary.

Available at Leading Pharmacies . . . Write for Literature



U. S. STANDARD PRODUCTS CO. Woodworth, Wisconsin... U. S. A.

LT. COL. PATRICK LAWSON, Marietta, is now serving in Germany. He has been in Africa, Sicily, Italy, and France.

COLONEL LEE WILHITE, Perkins, is in charge of the hospital located at Pilsen in Czechoslovakia. Colonel Wilhite has written friends concerning the sick, undernourished and homeless babies and children of the European countries. The pitiful war waifs were suffering from tuberculosis, ear infections and enteritis. Hundreds of homeless children are believed to be wandering between the American and Russian lines. These children are only one of the many problems confronting the hospital. Col. Wilhite says, "It is beyond imagination. There have been times when we had to establish 1,000 bed hospitals overnight." He says that the German physicians apparently amputate more freely than Allied medical men. He found more than 1,000 amputation cases in one hospital. "In some places conditions were so bad that people died as we walked into the rooms. The buildings were all filthy. In one place, what I thought was a spilled package of tobacco on a patient's blanket, turned out to be a pile of lice."

CAPTAIN R. W. CHOICE, Wakita, described in a recent letter, the horrors of the German prison camps:

"Today I saw the most horrible sight I have ever witnessed. I hesitate to even write about it but I think you would like to know just what we are doing. I took one medical officer and four medical technicians to visit a big concentration camp full of allied prisoners. There were 20,000 present, 400 of which were hospital cases. These people were herded into wooden barracks not as good as our barns. The sleeping quarters were built along the wall in tiers of three and the men slept without blankets. Each bed was about the size of a big bed and at times 16 men had to sleep in such a small place. This made it impossible for them to sleep on their backs so they all slept on their sides.

"In one place were 500 men with dysentery, so sick and wasted away they could not even get up. You can imagine the condition of that place.

"There were hundreds of men who were nothing but skin and bones, nearly starved by the Germans. I could count every rib, their legs and arms were just bones with skin on them and the faces looked like skeletons.

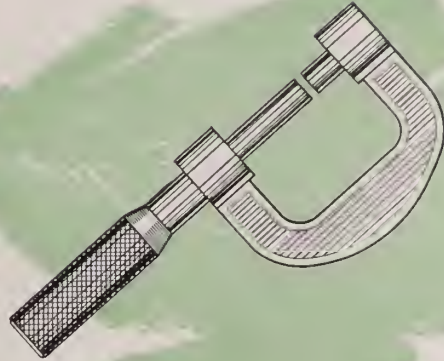
"I was taken to a small room where there was a huge pile of dead bodies that had been starved to death. The sight made me sick and mad. I wanted to kill every German that ever lived.

"The prisoners had only a little thin soup daily so filthy it was almost impossible to eat. One of the inmates told me that when one of them died the men sleeping with him kept him in bed as long as they could in order to get his ration of food. Our guide was Marshal Foch's aide in the last war and he had been a prisoner there for four years.

"The Germans had a torture and experimenting room where they tortured their victims with about everything a human brain could think of. When the prisoners went into this place they never came back. One form of punishment was to strip two inmates, tie their hands behind their backs, tie them together and make them stand in the prison yard for three days without food. Ever so often they poured water on them. This country is high and I am cold with plenty of clothes on so you can imagine how cold it was on these poor devils.

"The camp is overcrowded with 20,000 men, but at one time there were 80,000. For all these there was a room about the size of Nichols store.

"As we walked through the buildings there was all kinds of mixed emotions among the inmates, and I might add, all of us. Some of them would take off their hats and stand at attention (university professors, some of our greatest doctors, etc.) all of them clapped their hands and wanted to shake our hands or just touch us.



Precision Instrument

When medical science developed liver therapy, it found a "precision instrument" for dealing with pernicious anemia.

But a precision instrument, no matter what its design, is only so reliable as the toolmaker who produces it. *Likewise liver extract.*

Purified Solution of Liver, Smith-Dorsey, will give you uniform purity and potency for the treatment of pernicious anemia. It is manufactured under conditions which meet strict professional requirements. Laboratories are capably staffed; facilities are modern; production is carefully standardized.

For precision in liver therapy, you may rely upon

PURIFIED SOLUTION OF

Liver

SMITH-DORSEY

Supplied in the following dosage forms: 1 cc. ampoules and 10 cc. and 30 cc. ampoule vials, each containing 10 U. S. P. Injectable Units per cc.

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Lincoln, Nebraska

Manufacturers of Pharmaceuticals to the Medical Profession Since 1908

MAICO

Presents the Stethetron



At Last...

a compact, light-weight ELECTRONIC Stethoscope!

MAICO presents the STETHETRON

For the first time, there is now available to the medical profession a small, highly efficient electronic instrument for quicker, easier, more accurate auscultatory diagnosis.

The Stethetron not only intensifies body sounds, but enables the physician to emphasize particular sounds while subduing others. Rales and heart murmurs, extremely important in diagnosis but often scarcely distinguishable with an acoustic stethoscope, may be intensified many fold, and given greater relative prominence by subduing the normal heartbeat sounds. Both volume and tonal emphasis may be regulated at will.

Being self-powered with tiny hearing-aid batteries, the Stethetron may be used anywhere. Its trim, compact case may be suspended from a strap worn around the neck or may be laid on a desk or table while in use.

The Stethetron is the fruit of years of research and patient collaboration of physicians and engineers. It is the latest achievement of an organization that has long pioneered in medical electronics—an organization that has attained notable recognition in the medical profession by supplying 90 per cent of America's precision audiometers.

MAICO

PIONEERS IN MEDICAL ELECTRONICS

Write for Descriptive Booklet,

"A NEW ERA IN AUSCULTATION"

MAICO OF FORT WORTH

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FT. WORTH, TEXAS

AUDIOMETERS — HEARING AIDS

It was pitiful to see the sick ones try to wave at us. "I can hardly believe that I have seen all these things and every horror I see makes me more thankful we can take care of these atrocities over here instead of having our children experience German torture in the United States."

CAPTAIN BRUNO L. BONUCCI, Shawnee, recently had a very busy obstetrical day in Germany. He received an emergency call to a civilian home to deliver a child. There was not one child to deliver, but three! Triplets had been born to the German woman, and delivered by an American doctor. The babies, all boys, are healthy and weighed at birth something over three pounds each. Named in order of their birth, they are Sigfried, Herbert and Bruno. The last one was named in honor of Captain Bonucci who worked for fifteen minutes to save his life.

CAPTAIN WOODROW L. PICKHARDT, Lawton, is on his way home. A paratroop doctor, Captain Pickhardt was first reported missing the day after the Normandy invasion and then began weeks of anxious waiting for additional information by his relatives. Last August Mrs. Pickhardt was advised by a War Department telegram that her husband was a prisoner of the Germans.

Classified Advertisements

FOR SALE OR LEASE: Modern office building with reception room, four treatment rooms, private office and laboratory; air conditioned; fully equipped for general practice. Established practice complete with case records. Contact Mrs. R. D. Watson, 201 Britton, Ave., Britton, Oklahoma.

FOR SALE: 18 bed, modern equipped hospital and nurses quarters, located in small industrial community. Ground landscaped, covering one-half city block. Will sell, including equipment, at sacrifice. Contact Key T care the Journal.

Obituaries

U. G. Hall, M.D.
1884-1945

On March 29, Dr. U. G. Hall of Copan, Oklahoma was instantly killed when his car was struck by the northbound Santa Fe streamliner while he was driving across the main street railroad crossing.

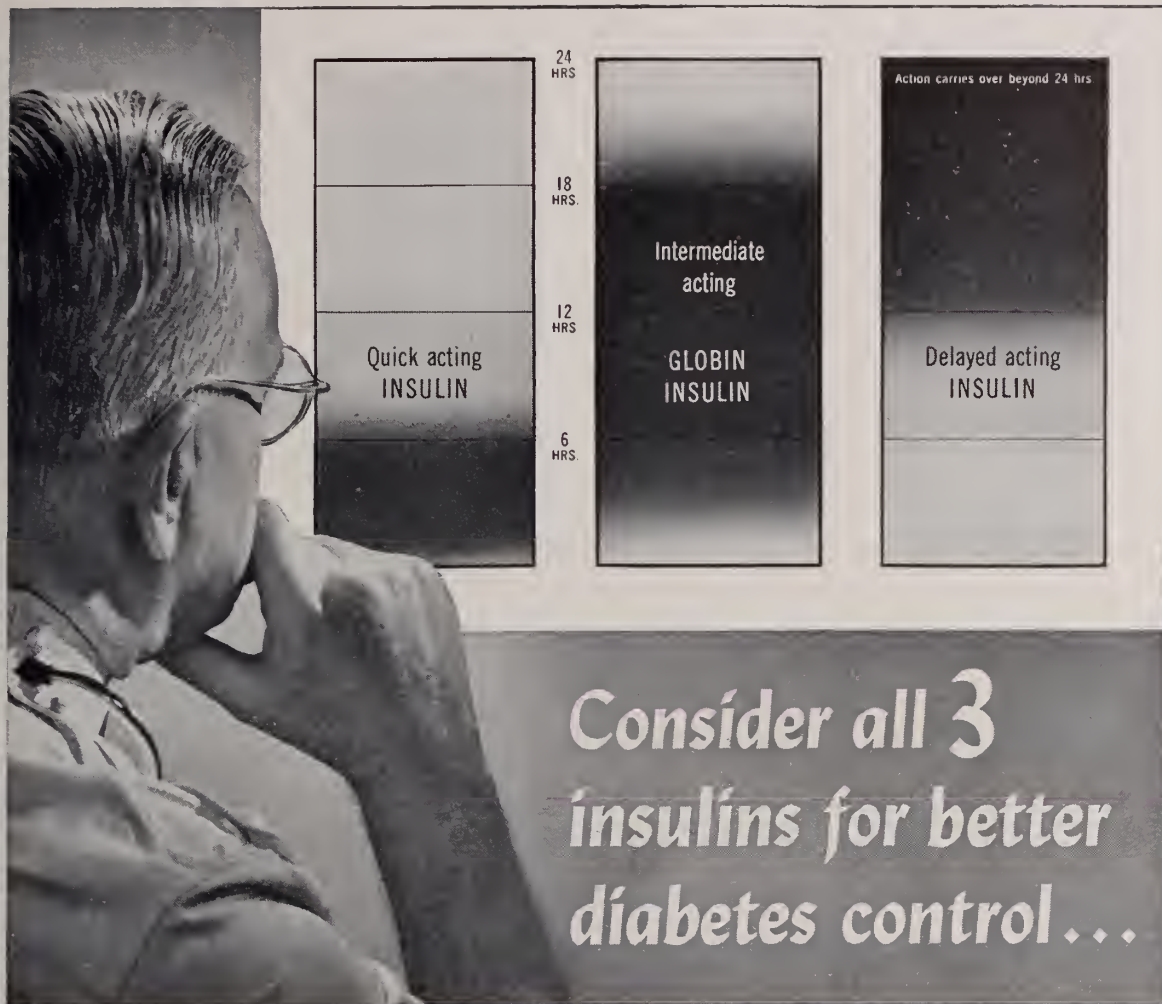
Dr. Hall was graduated from the Medical College of Kansas City in 1911. He had been practicing in Copan for the past 16 years. He is survived by his widow, Mrs. Fannie Hall, two daughters, Mrs. Jean Kleckner and Mrs. Cleathel Dobbs, of Bartlesville and a son Joe Hall of Bartlesville.

Edward S. Weaver, M.D.
1881-1945

Dr. Edward S. Weaver, Cordell, died at his home on April 5 after suffering a long illness.

Dr. Weaver was born at French Lick, Indiana and lived there until he began teaching school. In 1907 Dr. Weaver graduated from the University of Louisville School of Medicine, after which he came to Oklahoma and located at Dill, later going to Cordell. He was a lieutenant in World War I and served in France.

At the time of his death, Dr. Weaver was serving as city health officer for Cordell and as Washita county health physician. He was a member of the Washita County Medical Society, the Oklahoma State Medical



THE physician now has three types of insulin available to treat diabetes. One is quick-acting but short-lived. Another is slow-acting but long-lived. The new third one—'Wellcome' Globin Insulin with Zinc—is intermediate.

Action with Globin Insulin begins moderately quickly and persists for sixteen or more hours, sufficient to cover the period of maximum carbohydrate intake. By night, activity is sufficiently diminished so that the likelihood of nocturnal reactions is minimized. A single injection daily of 'Wellcome' Globin Insulin with Zinc will control the hyperglycemia of many diabetics. When a diabetic requires insulin therapy, the physician is wise to consider all three insulin types.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties.

Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U. S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc.

'Wellcome' Trademark Registered



'WELLCOME'
Globin  *Insulin*
WITH ZINC



Literature on request.

BURROUGHS WELLCOME & CO. (U. S. A.) INC., 9 & 11 EAST 41ST STREET, NEW YORK 17, N. Y.

Association and the American Medical Association. He was also a member of the Baptist church at Dill City and the Masonic lodge and Kiwanis club of Cordell.

Surviving Dr. Weaver are his wife; two sons, Lt. Ellis S. Weaver, U.S.N.R., Eddie S. Weaver of Altus; two grandchildren and three sisters.

**R. C. Bills, M.D.,
1864-1945**

Dr. R. C. Bills died at Lockhart, Texas on May 3 following a week's illness. He was formerly located at Soper, Oklahoma, having retired from active practice a number of years ago.

Dr. Bills came to the Indian Territory in 1895, beginning practice of medicine at Crowder Prairie in Choctaw county. Later he went to Jackson for four years, returning to Soper to locate permanently. He attended the Hospital Medical College, Memphis, Tenn., and the University of Tennessee School of Medicine. In 1907 he received his degree from Gates City Medical College, Texarkana.

Surviving Dr. Bills are three sisters and one brother.

**D. E. Little, M.D.
1878-1945**

Dr. D. E. Little, Eufaula, died on May 31 in Oklahoma City after a lingering illness.

Dr. Little came to Eufaula more than 30 years ago, where he has been a prominent and leading citizen. He was active in American Legion circles over the State, serving in World War I as a major. Dr. Little was a member of the McIntosh County Medical Society, the Oklahoma State Medical Association and the American Medical Association. He received his medical degree from the Ohio University School of Medicine in 1903.

Surviving Dr. Little are his widow, Marjorie Little and a brother, Scott Little of St. Louis, Missouri.

RESOLUTION

WHEREAS, Dr. Austin Hutchison of Bixby, Oklahoma, passed away last March 28, 1945, and

WHEREAS, Dr. Hutchison enjoyed the respect of the medical profession and of the public which he served for over a period of 50 years,

NOW THEREFORE, BE IT RESOLVED, That the Tulsa County Medical Society take this opportunity of expressing the sorrow of the membership at his passing, and to extend to Dr. Hutchison's many friends the sincerest sympathy of the medical profession.

Approved at the April 6 meeting of the Board of Trustees.

Welfare and Necrology Committee
J. W. Rogers, M.D., Chairman.

THE WILLIE CLINIC AND HOSPITAL

A private hospital for the diagnosis, study and treatment of all types of neurological and psychiatric cases. Equipped to give all forms of recognized therapy, including hyperpyrexia, insulin and metrazol treatments, when indicated. Consultation by appointment.

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Wholesome..
Refreshing

Safeguarded constantly by scientific tests, Coca-Cola is famous for its purity and wholesomeness. It's famous, too, for the thrill of its taste and for the happy after-sense of complete refreshment it always brings. Get a Coca-Cola, and get the feel of refreshment.





View of Bassinets where Polyclinic Babies Get off to a good start.

CHEERFUL NURSERY IS AIR-CONDITIONED

Polyclinic's nursery is a delightful place. It is refreshingly air conditioned from a central plant, which assures reliable temperature and humidity control. Fretfulness caused by heat discomforts is unknown here. Isolation technique is maintained for each bassinet.

Equipment is such as to assure absolute purity and cleanliness. The closest attention is paid to nursing care and proper feeding. In every detail adequate attention for the newly born infant is stressed.

POLYCLINIC HOSPITAL

THIRTEENTH and ROBINSON

OKLAHOMA CITY

MARVIN E. STOUT, M.D.
Owner

MEDICAL ABSTRACTS

TREATMENT OF FRACTURES OF THE TIBIAL CONDYLE, Robert A. Knight. Southern Med. Jr. Vol. 38, No. 4, April 1945.

The author reviews a series of one hundred thirty-four cases of this type of fracture; eighty-one of which were treated by conservative methods of fifty-three by operations. This type of fracture constitutes a small percentage of all fractures of the lower extremities, however, when it does occur, it demands exacting treatment because of the severe disability resulting from imperfect results. This type of fracture may result either from direct or indirect trauma. The majority result from a fall from some height with an associated torsional injury of the leg. The external condyle is most frequently involved, although any degree of injury may be present, varying from a slight fissure crack without displacement, to severe disorganization of the entire joint.

The degree and extent of the pathology are always much greater than is apparent from examining the x-rays. Cruciate ligaments are frequently found to be detached, from their attachments. The lateral ligament of the opposite side is also frequently torn or detached from its insertion. If there is any degree of displacement present, comminution of the articular surfaces may be very great. Some of the fragments lie even at right angle to the normal articular plane. The semilunar cartilage is usually torn and a portion may lie among the comminuted articular fragments. In cases of fracture of the medial condyle there is usually less comminution than in fracture of comparable degree involving the external condyle. This is probably due to the fact that the

internal condyle is not supported medially as is the external condyle laterally by the fibula. The associated ligamentous damage is also usually less extensive in fractures involving the medial condyle.

Treatment consists of conservative or operative methods. If more than one-fourth inch depression of the condyle is present, as compared with the opposite knee, the pathology within the joint is usually severe enough to warrant surgical treatment. If the outward displacement of the fracture is the major element of deformity, conservative manipulation may be done successfully. This consists of traction, angulation to overcorrect the deformity, and compression with a Bohler or similar type of clamp, and may improve the contour of the condyle sufficiently to obviate surgery. If displacement or depression persists after manipulation, open reduction should be done. After closed reduction the leg is immobilized in a cast for three weeks, followed by active motion and physical therapy for an additional three weeks. After six weeks following injury, a protective brace with an appropriate knock-knee or bowleg strap is fitted. The patient is then allowed up with crutches without weight bearing. Weight bearing should not be allowed before ten weeks following injury. The use of the brace is continued until the fracture is completely consolidated and control of the knee regained. Non-weight bearing motion should be begun early to encourage redevelopment of the quadriceps, and prevent adhesion formation.

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PLASTIC and GENERAL SURGERY
Dr. Curt von Wedel

TRAUMATIC and INDUSTRIAL
SURGERY
Dr. Clarence A. Gallagher

INTERNAL MEDICINE and DIAGNOSIS
Dr. Harry A. Daniels

Special attention to cardiac and gastro
intestinal diseases

Complete laboratory and X-ray facilities.
Electrocardiograph.

610 Northwest Ninth Street
Opposite St. Anthony's Hospital
Oklahoma City

Penicillin DOSAGE TABLE*

INDICATIONS	INITIAL DOSE (UNITS)	CONTINUING DOSAGE (UNITS)	UNITS IN 24 HR.	REMARKS
Serious Infections (staphylococcus, clostridium, hemolytic streptococcus, anaerobic streptococcus, pneumococcus, gonococcus, anthrax, meningococcus) Adults and children	15,000 to 20,000	(a) Intravenous drip: 2000 to 5000 every hr.	40,000 to 120,000 or more	(a) Dissolve ½ of 24 hr. dose in 1 liter (1000 cc.) normal saline; let drip at 30 to 40 drops per minute.
		or (b) Intramuscularly: 10,000 to 20,000 every 3 or 4 hr.	40,000 to 120,000 or more	(b) Concentration: 5000 U. per cc. normal saline.
		or (c) Intramuscular drip	40,000 to 120,000 or more	(c) Total daily dose in 250 cc. normal saline.
Infants	5000 to 10,000	3000 to 10,000 intramuscularly every 3 hr.	20,000 to 40,000 or more	Each dose in 1 or 2 cc. of normal saline.
Chronically infected compound injuries, osteomyelitis, etc. Adults and children	5000 to 10,000	10,000 every 2 hr. or 20,000 every 4 hr. intramuscularly or intravenously. Larger doses may be necessary at times.	40,000 to 120,000 or more	Concentration for intramuscular inj.: 5000 U. per cc. normal saline. For intravenous inj.: 1000 to 5000 U. per cc. Supplement with local treatment.
Gonorrhea	20,000 every 3 hr. intramuscularly for 5 doses		100,000	Results of treatment should be controlled by culture of exudate.
Empyema Adults and children	30,000 to 40,000 once or twice daily into empyema cavity		30,000 to 80,000	Dissolve in 20 to 40 cc. normal saline and inject into empyema cavity after aspiration of pus.
Meningitis Adults and children	10,000 once or twice daily into subarachnoid space or intracisternally		10,000 to 20,000	Concentration: 1000 U. per cc. normal saline.
Bacterial Endocarditis Adults and children	25,000 to 40,000	25,000 to 40,000 every 3 hr. intramuscularly	200,000 to 300,000	Continuous treatment for 3 weeks or longer. In a few cases the intravenous drip is more advantageous.

*Based upon recommendations by Chester S. Keefer, War Production Board Penicillin Leaflet, Apr. 1, 1945; and by Wallace E. Herrell and Roger L. J. Kennedy, *Journal of Pediatrics*, 25:505, Dec., 1944.

● Write for pocket size copies of this Dosage Table

Penicillin Calcium—Winthrop and Penicillin Sodium—Winthrop are available in vials (with rubber diaphragm stopper) of 100,000 and 200,000 Oxford Units.



WINTHROP CHEMICAL COMPANY, INC.
Pharmaceuticals of merit for the physician
NEW YORK 13, N. Y. WINDSOR, ONT.

Effective Convenient Economical

THE effectiveness of Mercurochrome has been demonstrated by more than twenty years of extensive clinical use. For professional convenience Mercurochrome is supplied in four forms—Aqueous Solution in Applicator Bottles for the treatment of minor wounds, Surgical Solution for preoperative skin disinfection, Tablets and Powder from which solutions of any desired concentration may readily be prepared.

Mercurochrome

(H. W. & D. brand of merbromin, dibromoxymercurofluorescein-sodium)

is economical because stock solutions may be dispensed quickly and at low cost. Stock solutions keep indefinitely.

Mercurochrome is antiseptic and relatively non-irritating and non-toxic in wounds.

Complete literature will be furnished on request.



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& DUNNING, INC.
BALTIMORE, MARYLAND**

If operative reduction is necessary, it consists essentially of thorough inspection of the interior of the joint, removal of all damaged soft tissue, removal of the semi-lunar cartilages, if they are torn, and reconstruction of the tibial plateaux, by means of compression and elevation. It is usually necessary to employ bone graft beneath the elevated plateau in order to hold it up in proper alignment. Also, it is frequently necessary to use some type of metallic internal fixation to stabilize reduction further. Following operative reduction the leg is immobilized in a long leg plaster cast with a pelvic band with about 15 degrees flexion at the knee. In two to three weeks this is removed and the leg suspended in balanced traction for beginning active and passive motion. Daily physical therapy is then instituted. After five or six weeks the patient is allowed up on crutches without weight bearing, keeping the leg protected by a long leg brace. If progress is satisfactory, partial weight bearing is usually begun eight to ten weeks post-operatively and full weight bearing in five to six months. The period of disability averages from seven to ten months in operative cases.—E.D.M., M.D.

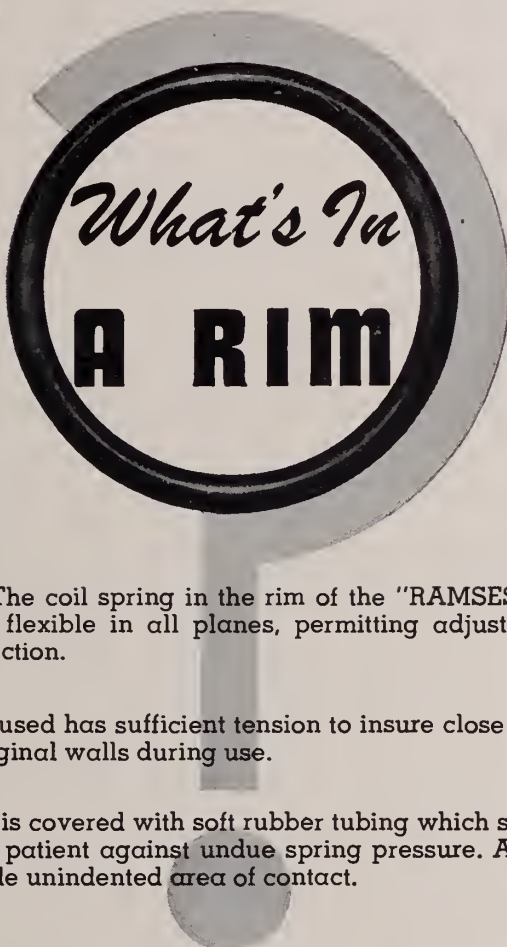
IRONSIDE, R., & BATCHELOR, I. R. C. The ocular manifestations of hysteria in relation to flying. *The British Journal of Ophthalmology*, volume 29, page 88-98, February 1945.

The peculiar nature of flying duties of an aviator throws particular strains upon the whole visual apparatus. The authors collected a series of 40 cases of ocular manifestations of hysteria in regular neuropsychiatric examination of aircrew. It is understandable that in pilots and other members of aircrews manifestations of hysteria should affect the eyes rather than the limbs, for what his legs are to the foot soldier, his eyes are to a pilot. The duties of pilot involve searching the ground and sky by day and night, looking constantly at dials and instruments of precision, and making judgments in conditions of varying visibility. The eyes are subjected to glare from the sun and from the sea, and sudden blinding by searchlights or by lightning flash.

Under conditions of fatigue, anoxia and anxious preoccupation certain visual aberrations may be noted even in normal individuals. There is a condition called fatigue spell in which, after hours of flying, the instrument panel becomes blurred or may appear to oscillate for a few seconds; the condition is usually rectified by shifting the gaze and shaking the head or rubbing the eyes.

The effects of anoxia on vision, particularly night vision, are well known. At high altitude the rate of retinal adaptation decreases considerably, and under conditions of anoxia almost all subjective ocular symptoms may occur. There may be felt a sudden brightening or a rose-red clouding of the visual field. Visual after-sensations may also be noted in conditions of anxious preoccupation. When crossing the coast-line after flying over the sea for long hours a vision of the waves may appear between the pilot and the land. This sensation rarely persists more than a few seconds. Diplopia may sometimes be experienced. When the eyes of a normal individual are directed upon a near point, more distant objects are seen double, and vice versa. All these phenomena are however normal or physiological, and should not be confused with psychoneurotic ocular symptoms.

The chief manifestations of ocular hysteria in pilots were blurred vision, photophobia, diplopia, defective night vision, visual hallucinations, lacrimation, intermittent visual failure with amnesia, aching eyes, difficulty in judging distances, blepharospasms, looking past objects, intermittent loss of vision in one eye, film over one eye, involuntary movement of one eye, jumbling of print, failing day vision. Any of these symptoms may be disabling considered in the setting of the duties which the individual has to perform. Even though some of these symptoms may seem slight in importance, it causes complete disability and it makes the pilot completely unreliable.



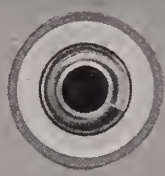
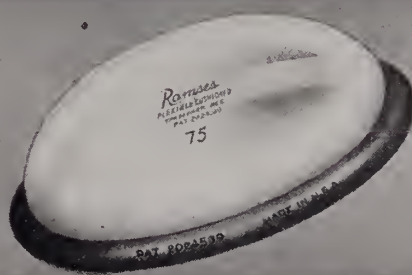
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The pilots observed the following visual hallucinations: approach (in focus) of objects in the upper parts of the visual fields, hairs of light around objects and wavy oscillations of the tops and bottoms of mountains; seeing coastlines that did not exist, on a clear day; bubbles in front of the eyes; flashes of red lights; micropsia in which the pilot saw everything as if looking through the wrong end of a telescope; there were also cases of temporary blindness, some lasting as long as 45 minutes. It was also found that there is, in a number of individuals, a correlation between phorias, convergence defects and neurotic constitution. Any inherent defect of the eye may form the nucleus for an aggregation of hysterical symptoms and signs.

From those who develop a hysterical reaction it is almost always possible to derive a history of personal neurotic traits or a family history of psychopathy, or both. A large number of those who develop ocular signs and symptoms of neurosis give a previous personal history of ocular instability or a family history of eye-trouble. Many of these individuals have suffered previously from eye-strain, have been sensitive to glare, and have worn spectacles at school. They have a constitutional liability to develop their symptoms. Yet, even individuals of relatively sound personality may develop hysteria under wartime conditions.

Treatment may be considered feasible in cases following a severe traumatic experience and in individuals who have a considerable number of flying hours or of operational hours to their credit. At first it is nearly always necessary to change the environment to suit the person. Orthoptic treatment of hysterics is unlikely to be permanently successful, although it has been shown that the suggestive and persuasive effect may carry the individual on for some time.—*M.D.H., M.D.*

WOUND IN THE EAR AND MASTOID REGION. R. Whitaker, M.D. *The Journal of Laryngology and Otology*, London, volume 59, pages 205-217, June 1944.

The author describes his experiences with the mastoid wounds observed during this war. His series consists of

thirty cases, including those with no bone injury to the mastoid demonstrated, those without infection, and those which became infected. The association of perforation and infection of the middle ear was frequent. It could be expected that this infection will spread to the injured mastoid process; yet, such a spread is rather rare, and, if it occurs, it can be treated by later mastoidectomy. A prophylactic exenteration of the mastoid cells was found to be unnecessary.

Interference, even in the infected mastoid, can be confined to removal of loose bone, without drainage of the mastoid cells or of the mastoid antrum. The cases cleared up more quickly after such a simple debridement. Conservative treatment for a week or two, to control and localize the infection, with sulfathiazole or sulfadiazine and infrequent local dressings undoubtedly shortens the period of illness, and in some cases operation has been unnecessary. With penicillin more generally available, infection can be prevented and controlled much more easily.

In treating early cases, excision and primary suture, with insufflation of penicillin, prevents the development of infection and leads to healing by first intention. Primary closure may be impossible owing to loss of skin or damage to the external auditory meatus. In such cases, debridement, removal of damaged skin and loose bone, with delayed suture, or healing by granulation is successful. Whether a meatal plastic operation is to be performed depends on the extent of the damage and infection. In general it is best left for a secondary operation. Forward treatment should be confined to control of hemorrhage and penicillin or sulfonamide and vaseline gauze dressing. The cases should be evacuated early, especially where there is x-ray or neurological evidence of the penetrating head injury and dural damage, when the case is primarily for a neurosurgeon.

X-ray of a fractured mastoid usually shows opacity and blurring of the cells as well as the bony injury. This is due to hemorrhage, but it may also suggest infection.

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Infection of the middle ear is almost inevitable if there is a perforation. And perforation is usually present, due to either a blast injury, or to the local explosive effect of the missile in the tissues. This infection, in the author's opinion, occurs because the patient is bandaged for some days, because blood and dirt get into the meatus at time of wounding, and because sometimes drops or powders are inserted to prevent infection, the latter being a bad practice. One should do nothing apart from inserting a piece of sterile cotton wool loosely into the meatus.

The wounded auricle heals well, with primary or secondary suture. The author's practice is to excise about 2 or 3 mm of the edge of torn cartilage, but only obviously damaged skin, and to suture the skin with fine waxed silk. The external auditory meatus has almost constantly shown swelling, hemorrhages, and desquamation, with the later appearance of persistent granulations. This may be due to sudden distortion and cracking by the explosive effect in the tissues of the missile passing close by, with cracking sometimes down to the cartilage. In treatment, regular, complete mopping out of debris and desquamated skin is essential, and the insertion of a wick or ribbon gauze in a suitable astringent or antiseptic of which silver nitrate, one-half to one

per cent, is the best. Granulations must sometimes be everted, but they usually disappear eventually after regular application of a suitable caustic such as chromic acid, 50 per cent.

Facial paralysis is not an indication for operation. There seems to be a fair chance for spontaneous recovery, even if associated deafness or spesis and severe bone damage are present. Exploration should be postponed; it is also often impracticable because the bone is loose and unstable.

In such cases the prognosis varies. Complete nerve deafness is permanent. Middle-ear deafness associates with perforation and otitis media usually improves as the infection abates. The prognosis of facial paralysis is difficult to judge. If the labyrinth is destroyed, vertigo is usually extreme at first, but as the destruction may heal, with the abatement of infection, subjective vertigo slowly disappears; yet, nystagmus may persist for a good while.—*M.D.H., M.D.*

FREQUENCY AND LOCATION OF PUNCTATE OPACITIES IN THREE HUNDRED YOUNG CRYSTALLINE LENSES. J. Bellows, M.D. *Archives of Ophthalmology*, volume 33, pages 229-236, March 1945.

Opacity of young lenses is so common that it has been considered physiologic by some ophthalmologists. The author examined the incidence of lens opacities in Americans between 18 and 40 years of age. Slit lamp examinations were made while the eyes were under homatropine cycloplegia.

Only 8 of the 300 eyes examined were entirely free of opacities of the lens. All others showed punctate opacities in one or more sections of the lens. Sixty-eight eyes (or 23 per cent) contained opacities in the region between the anterior band of the lens and the posterior surface of the anterior band of disjunction. In 227 eyes, (or in 76 per cent) the opacities were deeper in the lens, between the band of disjunction and the region of the anterior Y star. In the central portions of the lens the opacities diminished in number (44 eyes had opacities in the anterior Y region, 6 eyes in the central dark interval, and 56 eyes in the posterior Y region). The deep posterior cortex had numerous opacities (179 eyes, or 60 per cent.)

In 22 per cent of the eyes the opacities were predominantly in the nasal portions of the lens. Coronary cataracts were found bilaterally in six subjects; in two of them the opacities were well developed and were associated with cataracta cerulea. Peripheral concentric lamellar opacities were present in 15 eyes. Nuclear relief was observed in 8 eyes (of persons over 35 years of age). The size of opacities varied from 20 to 200 microns. Since these opacities increase in number with age, they must be considered forms of presenile cataract. Their presence in otherwise healthy persons is considered normal and physiological.—*M.D.H., M.D.*

KEY

M.D.H., M.D.Marvin D. Henley, M.D.
E.D.M., M.D.Earl D. McBride, M.D.

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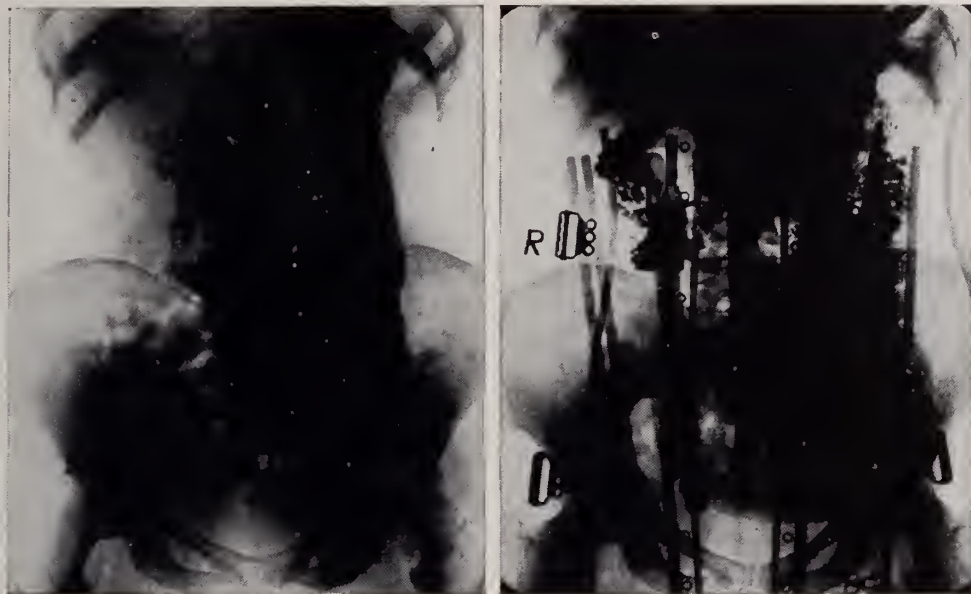
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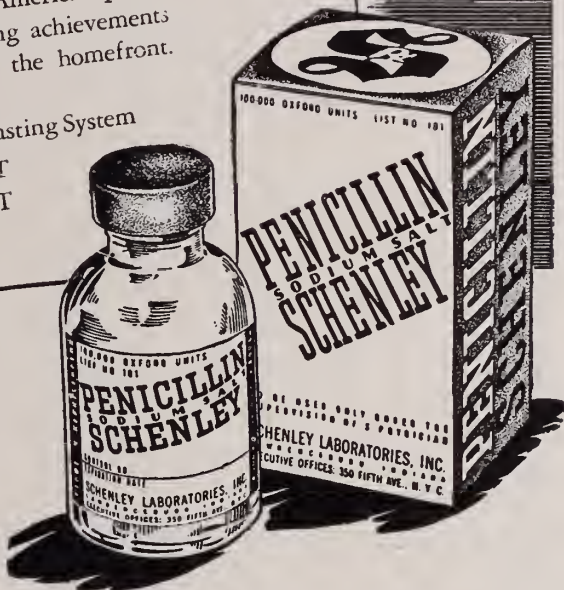
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Alfalfa.....	H. E. Huston, Cherokee	L. T. Lancaster, Cherokee	Last Tues. each Second Month
Atoka-Coal.....	C. D. Dale, Atoka	J. S. Fulton, Atoka	
Beckham.....	G. H. Stagner, Erick	O. C. Standifer, Elk City	Second Tuesday
Blaine.....	Virginia Curtin, Watonga	W. F. Griffin, Watonga	
Bryan.....	W. A. Hyde, Durant	W. K. Haynie, Durant	Second Tuesday
Caddo.....	C. B. Sullivan, Carnegie	P. H. Anderson, Anadarko	
Canadian.....	P. F. Herod, El Reno	A. L. Johnson, El Reno	Subject to call
Carter.....	J. L. Cox, Ardmore	H. A. Higgins, Ardmore	Second Tuesday
Cherokee.....	P. H. Medearis, Tahlequah	W. M. Wood, Tahlequah	First Tuesday
Choctaw.....	O. R. Gregg, Hugo	E. A. Johnson, Hugo	
Cleveland.....	Iva S. Merritt, Norman	O. M. Woodson, Norman	Thursday nights
Comanche.....	W. F. Lewis, Lawton	W. C. Cole, Lawton	
Cotton.....	G. W. Baker, Walters	Mollie F. Seism, Walters	Third Friday
Craig.....	Lloyd H. McPike, Vinita	J. M. McMillan, Vinita	
Creek.....	C. R. McDonald, Mannford	Philip Joseph, Sapulpa	
Custer.....	T. A. Boyd, Weatherford	W. H. Smith, Clinton	Third Thursday
Garfield.....	P. W. Hopkins, Enid	John R. Walker, Enid	Fourth Thursday
Garvin.....	Marvin E. Robberson, Wynnewood	John R. Callaway, Pauls Valley	Wednesday before Third Thursday
Grady.....	Roy E. Emanuel, Chickasha	Rebecca H. Mason, Chickasha	Third Thursday
Grant.....	I. V. Hardy, Medford	F. P. Robinson, Nash	
Greer.....	R. W. Lewis, Granite	J. B. Hollis, Mangum	
Harmon.....	W. G. Husband, Hollis	R. H. Lynch, Hollis	First Wednesday
Haskell.....	William Carson, Keota	N. K. Williams, McCurtain	
Hughes.....	H. A. Howell, Holdenville	Imogene Mayfield, Holdenville	First Friday
Jackson.....	C. G. Spears, Altus	E. A. Abernethy, Altus	Last Monday
Jefferson.....	F. M. Edwards, Ringling	J. I. Derr, Waurika	Second Monday
Kay.....	Dewey Mathews, Tonkawa	G. H. Yeary, Newkirk	Second Thursday
Kingfisher.....	B. I. Townsend, Hennessey	A. O. Meredith, Kingfisher	
Kiowa.....	J. P. Braun, Hobart	William Bernell, Hobart	
LeFlore.....	Neeson Rolle, Poteau	Rush L. Wright, Poteau	
Lincoln.....	U. E. Nickell, Davenport	C. W. Robertson, Chandler	First Wednesday
Logan.....	J. L. LeHew, Jr., Guthrie	J. E. Souther, Guthrie	Last Tuesday
Marshall.....	J. L. Holland, Madill	J. F. York, Madill	
Mayes.....	S. C. Rutherford, Locust Grove	B. L. Morrow, Salina	
McClain.....	J. E. Cochrane, Byars	W. C. McCurdy, Jr., Purcell	
McCurtain.....	J. T. Moreland, Idabel	R. H. Sherrill, Broken Bow	Fourth Tuesday
McIntosh.....	J. Howard Baker, Eufaula	Wm. A. Tolleson, Eufaula	First Thursday
Muskogee-Sequoyah			
Wagoner.....	H. A. Scott, Muskogee	D. Evelyn Miller, Muskogee	First Monday
Noble.....	D. F. Coldiron, Perry	Jess W. Driver, Perry	
Okfuskee.....	W. P. Jenkins, Okemah	M. L. Whitney, Okemah	Second Monday
Oklahoma.....	Gregory E. Stanbro, Okla. City	Ben H. Nicholson, Okla. City	Fourth Tuesday
Okmulgee.....	W. M. Haynes, Henryetta	J. C. Matheney, Okmulgee	Second Monday
Osage.....	G. K. Hemphill, Pawhuska	C. R. Weirich, Pawhuska	Third Monday
Ottawa.....	P. J. Cunningham, Miami	L. P. Hetherington, Miami	Second Thursday
Pawnee.....	E. T. Robinson, Cleveland	R. L. Browning, Pawnee	
Payne.....	Haskell Smith, Stillwater	A. C. Reding, Stillwater	Third Thursday
Pittsburg.....	L. N. Dakil, McAlester	A. R. Stough, McAlester	Third Friday
Pontotoc-Murray.....	Ollie McBride, Ada	R. H. Mayes, Ada	First Wednesday
Pottawatomie.....	Chas. W. Haygood, Shawnee	Clinton Gallaher, Shawnee	First and Third Saturday
Pushmataha.....	John S. Lawson, Clayton	B. M. Huckabay, Antlers	
Rogers.....	K. D. Jennings, Chelsea	Chas. L. Caldwell, Chelsea	Third Wednesday
Seminole.....	A. A. Walker, Wewoka	Mack I. Shanholtz, Wewoka	Third Wednesday
Stephens.....	W. K. Walker, Marlow	E. H. Lindley, Duncan	
Texas.....	R. G. Obermiller, Texhoma	Morris Smith, Guymon	
Tillman.....	W. A. Fuqua, Grandfield	O. G. Bacon, Frederick	
Tulsa.....	H. A. Ruprecht, Tulsa	E. O. Johnson, Tulsa	Second and Fourth Monday
Washington-Nowata.....	J. V. Athey, Bartlesville	S. A. Lang, Nowata	Second Wednesday
Washita.....	A. S. Neal, Cordell	James F. McMurry, Sentinel	
Woods.....	O. E. Templin, Alva	I. F. Stephenson, Alva	Last Tuesday
Woodward.....	Roy Newman, Shattuck	C. W. Tedrowe, Woodward	Odd Months Second Thursday

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NUMBER 8

The Association of Latent Vertical Phoria With Endocrine Dyscrasia

E. H. COACHMAN, M.D.
MUSKOGEE, OKLAHOMA

Volumes have been written upon the diagnosis and treatment of myopia, hyperopia, and astigmatism, while little has been said of latent vertical phoria and still less about the phoria being associated with some endocrine dysfunction. Latent phoria outranks any of these groups in frequency and is the one commonly undiagnosed, yet very easy to measure, and is nearly always associated with an abnormality of the endocrine chain.

There is much disagreement in the literature on even the *existence* of latent vertical phoria, although it has been discussed periodically since Von Graefe used the occlusion test to relax the extraocular muscles and measure the distance the eyes were apart in their vertical focus.

Such men as Lancaster (1), Berens (2), Duane (2), Roper (1), Bannon (1), Abrahams (3), and Beisbarth (4) represent the negative. The first five state it is but an artificial dissociation of the visual planes, and for that reason abandoned monocular occlusion as a method of *diagnosis*, yet continue its use for relief of symptoms, in the *treatment* of binocular visual complaints. The consistency of such isn't clear to me. Abrahams and Beisbarth are agreed that monocular occlusion simply demonstrates the normal tendency of the eyes to turn upward and outward when closed, such as in sleep or early stage of anaesthesia, and commonly called Bell's phenomena, but as a means of diagnosing vertical phoria, they condemn it on the scant strength of 29 cases, which were occluded from one hour to nine days.

The affirmative is represented by such men as Von Graefe (4), De'Schweinitz (5), Fuch's (6), O'Connor (7), Barkan (8),

Brown (9), Hughes (10), Worth (11), and Marlow (12). It is Marlow who has been chief standard bearer for the last quarter of a century, and in one series of 700 cases found 84 per cent showing latent hyperphoria of one-half prism diopter or more. It would astonish most oculists to learn that they fail to give 84 per cent of their cases adequate correction, by failing to search for latent vertical phoria. Furthermore, Marlow shows attention to details again is essential, by proving the period of necessary monocular occlusion varied from 24 hours to two weeks, with the average one week, before the latent phoria would show its maximum extent. All tests were made with full refractive correction in the trial frame and stenopoeic discs with horizontal slits no more than 3mm. wide in place to ensure visual lines passing through optical centers of the lenses, otherwise faulty head position could introduce a vertical error. Preocclusion findings are usually much smaller than the post occlusion measurements and for this reason the occlusion period is necessary. A ground glass lens, eye patch, or bandage serves to bring out the latent vertical phoria. We invariably occluded the eye with the lesser visual acuity because we felt the lessened visual acuity was due to lessened visual function. Marlow usually occluded the dominant eye. He found that right handed people were usually right eyed, but that the dominant eye did not always coincide with the eye of higher visual acuity. Alternate occlusion, he showed, will sometimes give a hyperphoria of both right and left eyes, an observation which he confirmed by comparing the hyperphoria in the oblique positions.

Marlow's procedure was as follows:

1. Determination of the phoria at 6 meters, (with refraction correction, base in prism for diplopia, and Maddox rod in phoropter or trial frame).
2. Measurement at 1/3 meters.
3. Relative sursumduction and abduction.
4. Hyperphoria in four oblique positions.
5. Near point of convergence.

It was success with Marlow's method of unearthing latent vertical phoria's that led to the observation of the *type* of patient usually displaying the phoria, answered to the description of hypothyroidism so thoroughly described by Howard (14), and is repeated here with occasional mutations:

The symptoms of hypothyroidism are remarkably constant and occur in this frequency:

(A) Ocular symptoms:

(1) The eyes are easily fatigued by close work and correcting lenses never seem comfortable unless a vertical prism is included. The patient generally thinks the glasses must be wrong so consults one oculist after another in order to obtain relief, but to no avail, unless an occlusion test for latent vertical phoria is done.

(2) Mild photophobia (sometimes severe) is a frequent complaint. The eyeballs ache, the eyelids burn and produce lacrimation, especially on sunny days.

(3) Line jumping is encountered such as skipping a line while reading. Bookkeepers are unable to follow the same line of figures across the page without getting off onto another line, while carpenters cannot saw lumber squarely across and end out of line from the starting point. Painters and paper hangers cannot run a straight line from the starting point, especially horizontally.

(B) General symptoms:

(1) Headache is always present especially deep between the eyes at the base of the nose, or unilaterally radiating to occiput, down neck to between shoulders, which is increased by reading, sewing, picture shows, riding in cars or trains, to even the point of nausea and vomiting. It is of a dull and prolonged character often present on awakening especially where card playing, reading etc. were done prior to retiring. In others it comes on late in the afternoon after a routine days work. Many cases have definite migraine with scintillating scotoma, and heat like waves before their eyes.

(2) General fatigue is common. The patient sleeps lightly, and wakes up tired. After dinner at night he feels drowsy and unable to read or participate in social affairs with pleasure, and finds it difficult to concentrate.

(3) There is a sensation of dizziness which increases by stooping over and straightening up.

(4) Aching, stiffness, cramping, and frequently "going to sleep" of the arms, hands, legs or feet, especially at night, or when sitting at a show or lecture, is common.

(5) Many cases catch cold easily and frequently develop "sinus trouble," which is why otologists should be alert to this condition. Chronic sinusitis is a frequent accompaniment, and benefitted by thyroid therapy.

(6) Habitual constipation is almost always a symptom.

(7) Loss or decrease of sexual power is frequent and is relieved by glandular therapy.

The signs are as constant as the symptoms.

(A) Ocular signs:

(1) Moderately diminished visual acuity in one eye is the rule and is associated with a vertical imbalance which is demonstrable only after 24 hours to two weeks of monocular occlusion.

(2) The range of accommodation is normal, except in low metabolic cases, but fatigues easily, which makes orthoptic exercises a real discomfort. Premature presbyopia generally occurs in long-standing cases of thyroid insufficiency.

(3) Occasionally moderate enlarged blind spots are present which return to normal size when the thyroid function reaches normal.

(4) Contraction of the peripheral fields is very common. The contraction seems to be somewhat proportionate to the degree of hypothyroidism. Contraction for red and green is relatively greater than that for white, the field for green being relatively the poorest. Since the fields may return to normal, except in cases of long standing and marked hypothyroidism, the contraction is probably a fatigue phenomenon.

(5) Distinct thinning of the outer one-third of the eyebrows is a common clue in adults as well as children.

(B) General signs:

(1) Generally overweight, often considerably, although rarely a patient may be underweight, but for other reasons, such as excessive smoking or hyperpyrexia.

(2) Expressionless face is common, and the patient looks puffy around the eyes and face, or heavily wrinkled from squinting continually.

(3) The skin is dry and sometimes scaly with a tendency to allergic eczemas. The hands feel dry and hard. The nails are brittle and the hair is dry.

(4) The temperature is always subnormal, the blood pressure low, the pulse rate

slow, and the lower one-third medial tibia area pits. The ankle pitting is due to water retention rather than myxomatous deposits, as suggested by increased urinary output with thyroid therapy, and urinalysis, heart examinations, and Wassermanns have all been negative. This suggests the possibility of edema in retinal detachment being caused from hypothyroidism, and was present in two of our cases. In case of fever, heavy tobacco users, or coffee drinkers, the pulse rate may be rapid, which complicates the diagnosis. Smoking and coffee drinking should be prohibited. The low blood pressure is the most constant finding. Mild secondary anemias are occasionally associated and relieved with thyroid therapy.

(5) Low basal metabolic rate (from minus 10 to minus 40 per cent) but often times within normal bounds if patient is ambulatory, since these cases tend to have a six per cent higher B.M.R. than when hospitalized according to Bothman.

(6) A quick and favorable response to thyroid gland therapy is the general rule. At first most cases should have their basal metabolic rate checked periodically. Once the signs and symptoms are mastered by the oculist the B.M.R. need not be done since the glandular therapy can be regulated by checking the temperature, pulse, blood pressure and ankle pitting monthly.

General observations have shown that both men and women are about equally affected with this syndrome and that it has a tendency to follow family groups since several in one family will be found to have significant amount of vertical phoria, while other families are free. Where both mother and father have the condition nearly all the children will show latent vertical phoria but where just one mate has vertical phoria, the majority of the children will usually show the same, even to the same amount in some instances.

The condition is found in myopes as well as hyperopes, and the patients examined have been scattered all over the United States since the relatives visiting the local Army camp have given excellent material for settling this point. Gentiles, Indians, Negroes, and Jews have all been found suffering from this syndrome and relieved with the above measures, so it is not racially confined. The majority tend to be of small stature (5' 6" or less) but we have found it in patients measuring over six feet, and it can be detected in early childhood. Post operative cataract cases will often show the same findings and be relieved by the same treatment.

With the conviction that latent vertical phoria and endocrine dyscrasia were associa-

ted, the following series of B.M.R. determinations are reported:

Name	Age	Latent Vertical Prism	B.M.R.
1. L. A.	32	2½ Right Base Up	Minus 16
2. P. B.	45	2 Right Base Down	Minus 15
3. Mrs. M. E. M.	64	None	Minus 18
4. Mrs. H. B. H.	31	2 Right Base Up	Minus 13
5. Mrs. G. B.	36	None	Minus 5
6. Mrs. R. R. R.	50	2½ Right Base Up	Minus 23
7. D. S.	26	½ Right Base Up	Minus 13
8. J. E. H.	47	2½ Right Base Up	Minus 14
9. T. G.	19	1 Right Base Up	Minus 14
10. I. C.	21	1 Right Base Up	Minus 25
11. Mrs. F. M.	37	2½ Right Base Up	Minus 10
12. Mrs. G. C.	65	2 Right Base Up	Minus 8
13. Mrs. W. A.	43	½ Right Base Down	Minus 7
14. A. G. P.	9	6½ Right Base Up	Minus 18
15. Mrs. M. L. M.	43	2½ Right Base Up	Minus 19
16. Mrs. E. M.	43	1½ Right Base Up	Minus 16
17. Mrs. S. W. W.	47	1 Right Base Up	Minus 16
18. Mrs. L. A.	38	None	Minus 10
19. G. S.	47	1 Right Base Up	Minus 16
20. Mrs. D. M.	43	3½ Right Base Up	Minus 13
21. R. E. M.	51	None	Minus 8
22. F. J.	26	1½ Right Base Up	Minus 17
23. E. L. M.	42	2 Right Base Up	Minus 22
24. J. B.	25	1 Right Base Up	Minus 18
25. C. W. L.	32	1½ Right Base Up	Minus 5
26. G. B.	41	1 Right Base Down	Plus 29
27. V. T.	16	1½ Right Base Up	Minus 12
28. I. E. W.	42	1½ Right Base Up	Minus 17
29. Mrs. M. S. B.	60	½ Right Base Up	Minus 4
30. Mrs. E. C.	42	None	Plus 2
31. P. A.	16	1 Right Base Up	Plus 4
32. H. G.	14	2 Right Base Up	Minus 27
33. R. W.	47	3½ Right Base Up	Minus 9
34. Mrs. G. R.	46	1 Right Base Up	Minus 10
35. Mrs. O. L. H.	22	2 Right Base Up	Minus 5
36. J. W. B.	31	2 Right Base Up	Minus 6
37. Mrs. W. H. L.	35	2½ Right Base Up	Zero
38. Mrs. W. W.	28	1½ Right Base Up	Plus 5
39. H. H.	15	1 Right Base Up	Minus 6
40. Mrs. D. M.	37	1 Right Base Up	Zero
41. Mrs. O. L. E.	25	2 Right Base Down	Minus 9
42. Mrs. J. H.	31	2½ Right Base Up	Plus 1
43. Mrs. A. T.	41	1 Right Base Up	Plus 1
44. Mrs. P. J. C.	32	2 Right Base Up	Plus 6
45. Mrs. W. S.	52	None	Minus 16
46. Miss C. S.	39	1 Right Base Up	Minus 2
47. J. E. M.	43	½ Right Base Up	Minus 9
48. E. M. C.	53	None	Minus 9
49. B. L.	22	1 Right Base Up	Minus 4
50. Mrs. J. A. M.	35	None	Minus 19
51. Miss C. F.	46	1½ Right Base Up	Minus 4
52. Mrs. F. E. T.	53	1 Right Base Down	Minus 3
53. Mrs. C. F.	26	2 Right Base Up	Minus 4
54. W. N.	61	2½ Right Base Up	Minus 3
55. C. W. W.	37	1½ Right Base Up	Minus 10
56. R. Q. H.	27	1½ Right Base Up	Minus 10
57. Mrs. E. E. L.	54	1 Right Base Up	Minus 3
58. Mrs. H. B. H.	31	3 Right Base Up	Minus 12
59. M. T.	42	3 Right Base Up	Plus 1
60. M. V.	20	2 Right Base Up	Minus 16
61. C. H.	31	4½ Right Base Up	Minus 17
62. Mrs. L. S.	44	2 Right Base Up	Minus 15
63. Mrs. R. M. W.	34	1½ Right Base Up	Minus 7
64. Mrs. F. T.	28	1 Right Base Up	Minus 11
65. Mrs. J. M.	56	1 Right Base Up	Minus 5
66. Mrs. P. T.	34	3½ Right Base Up	Minus 16
67. R. M.	38	2 Right Base Up	Plus 16
68. Mrs. J. E. T.	60	1½ Right Base Up	Minus 14
69. R. S. A.	42	1 Right Base Up	Minus 21
70. J. T. C.	15	½ Right Base Down	Plus 1
71. Mrs. L. D.	46	1½ Rt. Base Down	Minus 3
72. Mrs. E. S. S.	56	1 Right Base Down	Minus 13
73. Miss L. S.	52	½ Rt. Base Down	Minus 15

Name	Age	Latent Vertical Prism	B.M.R.
74. Mrs. C. H.	50	1 Right Base Down	Minus 18
75. Mrs. K. C.	30	2 Right Base Up	Plus 4
76. B. D.	42	2 Right Base Down	Minus 13
77. Miss E. W.	26	4 Right Base Up	Minus 25
78. Mr. I. L.	41	1 Right Base Up	Minus 3
79. Mr. T. M.	32	5 Right Base Up	Minus 15
80. Miss M. H.	36	1 Right Base Up	Minus 23
81. Mrs. A. D. L.	44	1 Right Base Up	Minus 15
82. Mrs. R. L. J.	46	1½ Right Base Up	Zero
83. Mrs. J. E. T.	60	1 Right Base Up	Minus 14
84. Mrs. C. B.	35	1 Right Base Up	Minus 30
85. Mrs. E. G.	27	7 Right Base Up	Minus 17

Table comparing prism and B.M.R.* results in the above 85 cases:

	Av. Ages	Av. latent vertical prism
27 Cases Minus 1 to Minus 10	38.5 yrs.	1.5
51 Cases Minus 11 to Minus 33	38 yrs.	1.81
2 Cases Plus 1 to Plus 10	22.5 yrs.	1.25
2 Cases Plus 11 to Plus 29	27 yrs.	1.75
3 Cases with zero reading	54 yrs.	0.5

* Bothman's (13) method of adding minus 6 to each ambulatory determination to make it equal a hospitalized bed rest determination was used in making these findings. Total extirpation of the thyroid will not give a B.M.R. of below minus 40 while hyperthyroidism will go much higher than plus 40, therefore minus readings should mean more to the clinician than a similar plus reading.

These determinations show that most of the cases tend to be on the minus side of the ledger, and that the vertical prism, on the average, is greater the higher the Basal Metabolism reading, whether it be plus or minus. In addition the 3 zero B.M.R. cases showed one-half prism vertical phoria, which might indicate the prism test the more delicate. It is interesting to note that although patients may become frightened during a B.M.R. determination and repeated determinations are necessary the prism measurements of the phoria do not vary, and are very constant although the patient's emotions may cause the B.M.R. to err. The symptoms and signs are reliable guides in classifying cases into hypo and hyper groups, since it isn't ordinarily difficult to differentiate a hypo from a hyperthyroidism, although they may show the same amount of latent vertical phoria.

Following these determinations, three cases of hypoglycemia were seen with average (1 to 3 dioptré) latent vertical phoria and several oophorectomy cases and diabetes mellitus have shown like amounts, so that the latent vertical phoria has come to mean a general, rather than a specific sign of endocrine dyscrasia, and does not implicate any particular gland since it is found in hypo as well as hyperactivity of these glands. In clinical numbers the great majority are hypothyroidism sufferers.

Unless a latent vertical phoria is correct-

ed before the final refractive prescription is given the patient's symptoms are immeasurably increased with improved vision, which is difficult to understand unless latent vertical phoria and aniseikonia are remembered, and the frequency of the phoria should give it first consideration. The great majority of vertical imbalances respond quickly to prism inclusion for their ocular relief and equally as promptly to adequate thyroid therapy for generalized comfort which suggests the two are inseparable associated and arise from the same endocrine disturbance, be it thyroid, ovarian, pancreas or otherwise. This belief is heightened also by the greater number of cases occurring just before the menopause, and continuing to plague until their condition is recognized and treatment instituted.

After seeing several cases that only thyroid therapy relieved, although other endocrine therapy, especially theelin, had been previously tried, we adopted the policy of giving these cases from 1 to 3 or 5 grains daily of thyroid, instructing the patient to eat their usual foods and take the thyroid only after meals. Vitamin B complex is best given daily to care for the increased demand during the accelerated metabolism.

If the case is refractory to thyroid, which occasionally will happen, further endocrine study is advised, but never yet have we found infection a constant associate of vertical phoria, while endocrine dyscrasias are invariably present, and furnish the clue, ophthalmologically, to unravel the systematic complaints. Therefore the oculist can many times diagnose hypothyroidism or some glandular dyscrasia before the internist has sufficient evidence to warrant a diagnosis, and saves the patient months of uncertainty and distress over his general "let down" condition, for certainly subnormal endocrine function will produce such a result. It behooves us as oculists not to overlook the general status of the patient in searching for the cause of ocular complaints.

CONCLUSIONS

(1) Latent vertical phoria is easily demonstrated by sufficient monocular occlusion and inclusion of the *full amount* of prism gives relief to the ocular complaint.

(2) Latent vertical phoria is a constant associate of endocrine dyscrasia, usually hypothyroidism, but may be found along with hypo or hyper function of other glands in the endocrine chain. Therefore it is a general and not a specific indicator of endocrine dysfunction.

(3) Latent vertical phoria can be easily demonstrated in children as well as adults, suffering from endocrine dyscrasia, and is an early sign, guiding the ophthalmologist to the diagnosis oftentimes before the internist can

arrive at one.

(4) Latent vertical phoria will demonstrate endocrine dysfunction much more frequently than generally recognized, and prism inclusion, with glandular therapy will give prompt and adequate relief to a large group formerly undiagnosed.

(5) The phoria, leg cramping and "going to sleep" of the extremities seemingly are muscular conditions brought about by lessened circulation as well as hormone deficiency because as the hormone levels and the circulation improves the patient's symptoms are relieved. The phoria tends to increase where hormone therapy is not administered.

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Anal Fistula*

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Anal fistula has occupied the attention of physicians since the beginning of recorded medical history, probably because of its dramatic onset with painful abscess formation and also because of its accessibility. John of Arderne, 1300-1370, described his method of treatment and illustrated it with rude diagrams. He emphasized the fact that the complete tract must be incised in order to cure the fistula. His method consisted of inserting a knife into the secondary opening through the tract and the internal opening into the rectum, then incising the entire tract. This method has been little improved upon in subsequent years.

DEFINITION

The term fistula means pipe or tube. Most contemporary authors classify this type as anal in origin because the primary or internal opening is located in a crypt in the anus lined by squamous epithelium. The usual designation of the openings of the tract have been "internal and external." However, it is probably more precise to refer to them as primary and secondary, because in some instances the entire tract may be inside the rectum, hence there would be two or more internal openings. The types of fistulae have been classified as internal and external—complete external, complete internal, or incomplete internal, or incomplete external. These are misnomers. The so-called incomplete ex-

ternal, in all probability, was a fistulous tract in which the primary opening was not demonstrated or it was a sinus and not a fistula at all. Therefore, it is more precise to speak merely of the primary and secondary openings and designating their anatomic location.

INCIDENCE

Anal fistulae occur at any age, from infancy to senility. The incidence varies according to authors. Bacon¹ reports that 25 per cent of all ano rectal diseases are fistulae. Buie² records fistulae seen in 5 per cent of all patients complaining of ano rectal symptoms.

ETIOLOGY

It is now generally accepted that the majority of fistulae originate as an infection in one of the anal crypts, burrowing beneath, through, or superficial to the sphincter mechanism and producing an abscess in the adjacent para-anal or para rectal tissues. Consequently, abscesses of these spaces may be in the supralelevator or infralevator spaces. Supralelevator abscesses may be pelvirectal or retrorectal and infralevator abscesses are ischio anal in location. These have been formally called ischio rectal but since they are bounded medially by the external anal sphincter and the insertion of the levator ani retrorectal and infralevator abscesses are ischio they are more properly designated ischio anal.

They may also be termed peri-rectal or pararectal, which are self-explanatory. There are

numerous causes for the incitation of the anal cryptitis which precedes the fistula formation. (1) Trauma: Irritation from enema tips—insertion of foreign bodies, ingestion and excretion of foreign bodies such as small pieces of bone, pieces of tooth picks, etc. (2) Chemical Causes: Improper injections of internal hemorrhoids, irrigation of the rectum with caustic solutions, etc. (3) Infectious Diseases of the rectum, and anus; tuberculosis: If routine specimens are examined from a large series of fistulectomies by histopathological means, and guinea-pig inoculations, approximately 10 per cent of all anal fistulae will be found to be tuberculosis; lymphopthia venerium; actinomycosis; degenerating carcinoma. Tucker and Helwig³ have demonstrated the presence of ducts opening into the anal crypts. These are lined at the opening with squamous epithelium and extend a varying distance subcutaneously. Some of them terminating into vestigial glands which are lined with columnar epithelium. They have identified these as rudimentary preen glands and hypothesized the presence of these glands and subsequent cryptitis as inciting factors in the production of the majority of anal fistulae. Hence, the fistula starts as an infection in an anal crypt and because of the resistance of the sphincter mechanism and the attachment of the levators extends into the areolar tissue of the infra or supralevator spaces producing an abscess. The abscess, in turn, ruptures spontaneously though the peri-anal skin or into an adjacent organ or back into the rectum proximal to the primary opening or it is incised, thus completing the fistulous tract. The fistula may, of course, originate from an anal fissure; this is rare, however, and this type of fistulae is subcutaneous. Complications occur with rupture of the abscess into a neighboring organ such as the vagina or urethra, or into the peritoneal cavity. The primary opening is usually in the posterior anal canal. Different investigators report varying percentages—from 56 to 80 per cent. The primary opening, however, can be in any location in the crypt margin.

SYMPTOMS

The earliest symptoms are pain and swelling produced by the formation of an abscess. Once drainage is established either surgically or spontaneously the patient complains of persistent or intermittent draining sinuses. Occasionally drainage may stop with apparent healing and not become reactivated for several years.

DIAGNOSIS

The history of draining sinuses or abscess formation around the anus leads to a presumptive diagnosis of an anal fistula. The differential diagnosis should include pyoderma, pilonidal disease, hydradenitis suppurativa,

peri anal lymphatic abscess. Establishment of a primary anal opening confirms the diagnosis of fistula. This is occasionally difficult to confirm but rather than to probe a tract unnecessarily in the office with much subsequent pain to the patient it is much simpler to complete the examination after the patient has been anesthetized. The anesthesia of choice being either spinal, caudal or trans-sacral.

Since the types of abscesses previously mentioned are but stages in the formation of anal fistulae, the treatment is considered along with that of fistulae. Once the diagnosis of abscess is established, drainage should be instituted by wide incision as soon as possible. The optimum time for drainage is difficult to state categorically. In general, the abscess should be fluctuant and allowed to "point" before opening. The incision should be made in the fluctuant area as near to the anal verge as possible without cutting through the fibres of the external or internal sphincters.

Various types of treatment for anal fistula have been described since the time of Hippocrates. He mentioned the use of a suture threaded through the primary and secondary openings, and tightened on successive days until the intervening tissue was cut through. This was the so-called "Seton Suture." Galvanism, the injection of various pastes, notably bismuth, cauterization, and the use of chemical solutions have all been uniformly unsuccessful. The only successful treatment is surgical.

The criteria for curative treatment consists of: 1. Finding the primary opening. 2. Tracing its connection with fistulous tracts. 3. Opening the tracts and the primary so that the wound may heal from within outward. 4. Proper postoperative care to insure that such healing takes place.

Some surgeons advocate, upon excision of the tract, that the wound be closed primarily. Occasionally healing by primary intention may occur but too large a per cent of fistulae recur with this method.

With complete relaxation of the sphincter produced preferably by trans-sacral or spinal anesthesia, the primary opening is demonstrated and a probe inserted through the primary into the fistulous tract, and if there are multiple secondary openings, their connection with the primary should be demonstrated. The overlying tissue is incised including any part of the sphincter mechanism which may be over the primary. If the involved tissue is not grossly necrotic, it is not necessary to excise the tracts completely. The edges of the wound are beveled so that they will not overhang and that there will be no overlapping in healing. If there are numerous subsidiary tracts incision or excision

of them is not essential once the primary opening and its immediately adjacent tracts heal, the source of infection is obliterated and lesser tracts will of consequence heal.

Care should be exercised in looking for the primary opening in the crypts. Too forceful probing will result in false openings. Some surgeons prefer to inject the tracts with methylene blue. However, once incised the dye diffuses throughout normal tissues and much tissue is needlessly sacrificed resulting in prolonged healing.

Numerous operations have been devised in an attempt to prevent anal incontinence. None of these have been successful. It is still essential to incise all the anal musculature overlying the primary opening regardless of its location. If the wound is not packed, or at least lightly packed, incontinence is seldom a problem. Multiple stage procedures accomplish no better postoperative continence than the one stage fistulectomy.

Internal fistulae with secondary openings inside the rectum present a somewhat different problem. The tract should be probed from primary to secondary opening and overlying rectal mucosa incised. It is sometimes necessary to excise the mucosa in order to prevent recurrence.

Tuberculous fistulae will respond to surgical treatment as readily as the non-specific

types if the patient's general condition is good and there is no active pulmonary disease.

Fistulae associated with acute ulceration diseases of the lower colon should be treated conservatively with no attempt at extensive fistulectomy until the colonic disease is quiescent.

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Pneumonia 100 Years Ago

The conviction is so general and so strong that this disease may be controlled by remedies, that it is hardly ever left to itself; and certainly no physician, in the present state of our knowledge, would be justified, merely for the purpose of elucidating and determining this question, in adopting such a course. But the positive and conclusive evidence derived from this comparison is not altogether wanting. It could hardly have escaped observation, that pneumonia might terminate in recovery, quite independent of any aid derived from medical art. —*Elisha Bartlett, An Inquiry into the Degree of Certainty in Medicine, 1948.*

How True

After recognizing the genius of young Schopenhauer and after instructing him in chromatics, Goethe loathing his presumptuous display of knowledge on one occasion, said:

"This life and its load I could gladlie shoulder
If pupils would wait to teach till they're older."
Something for doctors to think about.

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SPECIAL ARTICLE

LAENNEC 1761 — 1826 MANPOWER AND DISEASE*

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In the ancient kingdom of Brittany at the juncture of the rivers Steir and Odit stands the port of Quimper. It has been described as a city of fascinating quays, byways, fables and gables, with the sea not far away. But for all who are interested in the history of medicine, Quimper takes on much greater significance and stands encircled with the halo of immortality. On February 17, 1781, Rene Theophile Hyacinthe Laennec was born there. The house of his birth on the quay of the Steir has been replaced by another which now carries an inscription bearing his name, the dates of his birth and death, and the date of the publication of the first edition of his book, "*Traits de L'Auscultation Mediate* 1819." Also there is a statue of him in this quiet city erected by the doctors of France.

According to William Hale White,¹ "He was a pure Celt and is said to have been descended indirectly from the Breton poet Malherbe. Many of his family had been lawyers, some magistrates. His father, one of four brothers, was born in 1747, became a member of the Bar and held several appointments, such as those of *avocat au parlement de Bretagne*, *lieutenant de l'amirauté de Quimper* and *counseiller de prefecture* of the Department of Finistere, but with his flibbertigibbety temperament he rarely kept any post for long. He was a man with a charming manner, a cheerful disposition, good health, much literary culture, always writing poetry, but lacking common sense, proper pride and genius, he did nothing worth doing with his life."

Laennec's mother gave birth to four children within six years. The fourth child died within a few hours after birth and the mother expired two days later. The inept father was left with three small children, two sons and a daughter. The little girl was committed to the care of an aunt and the two boys to an uncle who looked after their education for awhile and then returned them to their father. This uncle later died of phthisis and no doubt he transmitted the same to his

young nephew Theophile. Soon the two boys were fortunate to be placed under the care of a more dependable uncle, Guillaume Laennec, who was a practicing physician of good character, professional skill and untiring energy. His influence upon the boy Theophile was profound. Dr. Guillaume Laennec lived in Nantes during the revolutionary upheaval and the boys had to take the backway to school in order to escape the gruesome sight of falling heads from the permanent guillotine immediately in front of their uncle's house.

When Laennec was 14 years of age his father married again and requested him to return home but the influence of his uncle was already molding his thought and action. He had observed his father's profligacy and indifference and decided to remain in Nantes. No doubt his plans for the study of medicine were well under way. With opposition from his father and little financial aid, he struggled through the horrors of the Revolution, always conscious of his poverty but ambitious to get on with his studies. We owe much to the wise uncle who knew how to deal with the parsimonious parent; how to protect, direct and inspire the otherwise neglected youth as he pursued the study of medicine with a well balanced, acquisitive mind, incredibly keen.

Laennec was admitted to the medical school, Hotel Dieu at Nantes when only 14 years of age. Soon thereafter he was appointed military surgeon third class, perhaps serving in this capacity at the Hospital La Paix with his guardian uncle. In spite of many duties in addition to his exacting studies and the strain of the war-like times, he found leisure in music, dancing and strolling in the country. He was expert with the flute, fond of nature and a student of botany.

Early in 1800 as *Officier de Sante* he accompanied the army to put down an insurrection between Nantes and Quimper. Soon he returned ready to go to Paris for the continuation of his medical studies only to be disappointed by his derelict father who failed to provide the necessary funds. Later, by legal action, his father was bound to supply

*This biographical sketch commemorates the 119th anniversary of Laennec's death.

the necessary money for tuition, board, clothing and lodging.

Upon his arrival in Paris, Laennec looked up his old friends from Nantes who had left him behind awaiting the tardy financial aid ultimately wrenched from his father by law. On May 2, 1881 he was admitted to *Ecole de Medicine*.

Thus far we have followed in brief detail the shocking poverty and the many obstacles, ever confronting this remarkable young devotee of medical science, in order that the reader may be inspired by his perseverance and may contrast his plight with the easy going career of our own medical students under government paternalism. We patiently await our rising Laennecs.

In addition to ill-fated paternity and embarrassing poverty, this ambitious youth was constantly contending with the ravages of ill health. White,¹ referring to his wretched health says, "he suffered from asthma, angina, insomnia, neurasthenia, and later from phthisis; more than once he nearly gave up his career in Paris for a life in the country." In that day, wanting Laennec's remarkable discoveries, all the symptoms and conditions mentioned by White might have resulted from the insidious development of phthisis without a satisfactory clue to their origin.

Surmounting all handicaps, Laennec became a student at La Charite where he worked three years under the celebrated Corvisart. During this time, in addition to other notes, he recorded extensive histories of all the cases coming under his observation. His untiring industry in this respect is well known by the following paragraph from the biographical sketch found in Forbes² translation of the third French edition of his work.

"Although attached in a more particular manner to the clinic of *La Charite*, Laennec attended the various medical lectures at that time delivered at The School of Medicine; and, as well by his talents and superior knowledge of the learned languages, as by his great zeal and assiduity in medical pursuits, he speedily attained a marked degree of distinction among the crowd of students then frequenting the Parisian hospitals. His remarkable industry at this period is best evinced by the fact, that during the first three years of his attendance as pupil of *La Charite*, he drew up a minute history of nearly four hundred cases of disease; and the talent and discrimination of the youthful reporter must appear equally conspicuous, when it is known that these very cases furnished the groundwork of all his future researches and discoveries. This fact (which I give on the authority of his cousin, Dr. Meriadec Laennec) ought to prove a stimulus to the industry of all students in their attend-

ance on hospital practice, and should teach them, that, to record every important case they meet with, is not only a most useful labor at the time, but may eventually lead, as in the case of the subject of this memoir, to results of the highest consequences to themselves and their profession. At an early period of his labors, he began to communicate some of their results to the public, and was honored with signal marks of professional distinction. In the year 1802, being then in his twenty-first year, he published in the *Journal de Medecine*, at that time conducted by Corvisart, Leroux, and Boyer, several papers of singular merit; and likewise obtained the two chief prizes in medicine and surgery, granted by the Minister of the Interior, through the then Institute of France. His first paper consists of an interesting case of diseased heart, and appeared in the number for Messidor, an. x. (1802). Two months later, in the same year (Fructidor, an. x.) he published his *Histoires d' Inflammation du Peritoine*, consisting of a series of cases detailed in a very clear and satisfactory manner, illustrated by much learned annotation, and terminated by general conclusions, specifying the anatomical character and signs of peritonitis in a more accurate manner than had been previously done. This memoir, which has the great merit of being six years anterior of the publication of Broussais' *Phlegmasies Chroniques*, is well worthy the attention of pathologists."

We have quoted freely from Forbes because few doctors are familiar with these important publications coming from the pen of the youthful Laennec before he produced his monumental work which first appeared in 1819. In addition to the above publications there were many lectures and medical papers representing unusual classical, scientific and linguistic attainments.

On June 11, 1804 he received his degree of Doctor in Medicine. Again quoting Forbes, "After his graduation, he entered formally upon the practice of medicine, and continued to devote himself to this and his medical studies, until obliged by ill health to relinquish both. His constitution, naturally feeble, and predisposed to disease, was unequal to the labors he imposed upon himself; and as his private practice increased, he felt himself under the necessity of relinquishing some of his employments. Accordingly he discontinued his course of pathological anatomy in 1806. This course attracted considerable attention during its continuance, and was in some degree founded on the lecturer's own discoveries and researches. The arrangement of it was quite original, and indicated at once a clear and a comprehensive mind."

In 1816 Laennec became chief physician to

Necker Hospital where, with untiring zeal and energy, he continued his clinical and pathological investigations. Soon after assuming his duties at Necker he made his immortal discovery of mediate auscultation and invented the stethoscope. The story of this discovery and the development of auscultation are well known to all students of medical history, yet the published accounts are so at variance we feel it wise to reproduce Laennec's own simple, classic account of this new diagnostic procedure which assumed world wide significance. The following is quoted from White's¹ translation.

"In 1816 I was consulted by a young woman presenting general symptoms of disease of the heart. Owing to her stoutness, little information could be gathered by application of the hand and percussion. The patient's age and sex did not permit me to resort to the kind of examination I have just described (i.e., direct application of the ear to the chest). I recalled a well-known acoustic phenomenon; namely, if you place your ear against one end of a wooden beam the scratch of a pin at the other extremity is most distinctly audible. It occurred to me that this physical property might serve a useful purpose in the case with which I was then dealing. Taking a sheaf of paper I rolled it into a very tight roll, one end of which I placed over the praecardial region, whilst I put my ear to the other. I was both surprised and gratified at being able to hear the beating of the heart with much greater clearness and distinctness than I had ever done before by direct application of my ear.

"I at once saw that this means might become a useful method of studying, not only the beating of the heart, but likewise all movements capable of producing sound in the thoracic cavity, and that consequently it might serve for the investigation of respiration, the voice, rales and even possibly the movements of a liquid effused into the pleural cavity or pericardium.

"With this conviction, I at once began and have continued to the present time, a series of observations at the Hospital Necker. As a result I have obtained many new and certain signs, most of which are striking, easy of recognition, and calculated perhaps to render the diagnosis of nearly all complaints of the lungs, pleurae and heart both more certain and more circumstantial, than the surgical diagnosis obtained by use of the sound or by introduction of the finger."

Perhaps the greatest significance of this discovery is to be found in its stimulating effect upon Laennec's own desire to perfect physical exploration of the thoracic organs and the focusing of attention upon auscultation by his pupils and his writings through-

out the world.

Promptly he grasped the significance of the clinicopathological implications and with avid genius, appropriated all previous scientific advances as he entered upon his monumental career. Through the close correlation of bedside and post mortem findings, he helped to lay the "foundation stone"³ of modern knowledge of diseases of the chest. When he came upon the scene the diagnosis of diseases of the lungs and heart was still more difficult than that of other internal organs. In a short time he had made the most exacting diagnostic tasks relatively easy. In half the time now allotted for a medical education, virtually without chart or compass, he "observed, recorded, tabulated and communicated" practically all that is now taught with reference to the physical diagnosis of diseases of the thorax. His voluminous work of nearly 800 pages on auscultation and diseases of the chest was published in 1819 and translated into English by Forbes in 1821. In his own words, "The diagnostic establishment by means of the cylinder during life, was verified by a study of pathological conditions found at autopsy." Laennec's revival and amplification of auscultation and his invention of the stethoscope enabled Corvisart to check the results of percussion in the living body, whereas Auenbrugger may have failed to establish the value of his method because he could confirm his observations only at autopsy. Corvisart rendered a great service by translating Auenbrugger's work on percussion and placing behind this important diagnostic procedure the authority of his knowledge and the power of his position at this opportune time.

Before his book was ready for the press, Laennec was completely broken in health and had to leave Paris for rest. More truly than anyone who had gone before, he brought together the varied clinical and pathologic manifestations of tuberculosis and proclaimed "the unity of phthisis." Strange to say at this time he seemed not to realize that he was exhibiting the classical manifestations of phthisis.

Soon he returned but was too frail to follow the urgent call of his insatiable genius. He gave up and went home in despair of ever returning, but two years later he was again in Paris hard at work. For four and a half years he worked with incredible endurance and accomplishment, receiving many honors and wide acclaim. But during the spring of 1826, when he was 45 years of age, while correcting the proofs for the second edition of his book, he concluded he was dying of phthisis. He then realized that his thin, tired body could no longer pursue his soaring ambitions. Weakness, fever, diarrhea, night-sweats and sore throat, turned his

thoughts toward his beloved Brittany .The journey home in a carriage purchased for the purpose was devastating. But he was on the road to Brittany and the "Place of the Foxes" was a good place to die. There were willing neighbors, friendly skies, "warm sunshine, the blue sea and white gulls."

The weeks passed, emaciation progressed leaving only skin and bones; expectoration increased, diarrhea took its toll; the hectic flush became articulate as fever rose and fell; the pulse raced riotously under the lash of terminal toxemia; the alert mind occasionally wavered only to renew its hopeless struggle with death.

Ultimately on August 13, 1826, Laennec submitted to his fate with graceful acquiescence. No doubt this great diagnostician who, so often had placed the discerning ear over

the seat of life only to discover the signals of death, knew the end was near at hand. At 3 o'clock in the afternoon he calmly removed the rings from his fingers and placed them on the bedside table. When his wife sought the reason, he quietly replied that it would soon be necessary and he wanted to save others the trouble. Two hours later, his spirit was on its way, no doubt passing the white gulls between sun and sea unnoticed. Thus the life of Laennec ended but his influence encircled the world for the everlasting benefit of mankind.

1. Selected Passages from *De l'Auscultation Mediate*, R. Theophile H. Laennec. With a Biography by Sir William Hale-White. p. 1. William Wood & Co., New York. 1923.

2. A Treatise on the Diseases of the Chest, and on Mediate Auscultation, R. T. H. Laennec. Translated from the Third French Edition by John Forbes, to which are added the notes of Professor Andral. pp. xx, xxi, xxii. Samuel S. and William Wood. Philadelphia, 1938.

3. Korns, Horace Marshall. *Annals of Medical History*. Third series, Vol. 1, No. 1, p. 52. January, 1939.

FORUM

This letter is published through the request of the President, the Editorial Board and several members.

June 25, 1945.

Senator Robert F. Wagner,
U. S. Senate,
Washington, D. C.

Dear Senator Wagner:—

As a member of the Editorial Board of the Journal of the Oklahoma State Medical Association may I acknowledge the receipt of your letter and the copy of your speech before the Senate. I feel that you should not be surprised when I tell you that we have no space in the Journal for this material. Your proposals with reference to medical legislation are well known to the doctors of the State because much space in the Journal has been occupied with informative articles warning the doctors and the people against regimented medicine in any form. Since your Bill has been reintroduced, this policy shall be continued.

Now, speaking as an humble citizen and a member of the medical profession, may I say that I could be more patient with you and your program if I did not feel sure that you are at least partially aware of what you are trying to do to a great free enterprise which has given to the American people the best medical service ever vouchsafed to any comparable nation.

Medicine has reached its present high mark through an evolutionary process following the path which nature walks. Any change which causes a deviation from this

path is dangerous to the welfare of our nation. Washington bureaucrats are now knee deep in trouble because, contrary to nature's way, they have plowed up, turned under, burned and killed the products of the soil and, without sufficient knowledge of fundamentals, they have monkeyed with supply and demand and paid people not to plant, or unwisely to plant less than they, as farmers, believed they should. It is my understanding that you are having a little trouble with your existing so-called social security. If you had struggled through eight years (the minimum for doctors) of formal education in government and statesmanship before you entered politics, I might feel more secure about your part in law-making, but even then I would question your ability to pass judgment on the merits of medical service and to provide ways and means for its application and distribution.

Bismarck instituted social security including compulsory health insurance in Germany with the avowed purpose of placing the common people under obligation to the Government. A bit of political expediency which, in addition to other evil consequences ultimately snuffed the rising flame of medical science in Germany. Who can say how much the program had to do with the mass psychology which prepared the way for Hitler and his followers. Friedrich Schiller, who laid down the principles of democracy and set forth the tenets for which we fight today, would turn over in his grave if he knew what you and your co-workers are trying to do to a free

people. In this connection it is significant that Schiller became an exile from his own Wurtemberg rather than practice medicine under the regimentation of Duke Charles. Under German social security the quality of medicine declined and the costs mounted. No Heinies, Goethies or Schillers appeared to stabilize a waning social order. Schiller had the courage to walk out on his imperious Duke, Goethe as Minister-in-charge at Weimer, under the roar of Napoleon's cannon at nearby Jena, bravely waited to face the victorious Emperor. The Grand Duke and his court had fled but Goethe was not afraid. Heine had the courage to place his finger on the obstacles which doctors were meeting in their attempt to advance the cause of public health throughout the civilized world, namely business interests and tenement owners often operating under political protection.

When the end came to Germany, courage was supplanted by flight and self-administered poison. The latter often retained in the mouth where at the opportune moment chattering teeth might nip the vial and release the lethal dose. No Nipponese faith inspires this cowardly act. Rather, it represents the mark of stark degeneracy under a dissolute and wrecked government. If you cherish the approval of posterity you should reconsider your plans for medical service and promptly retrieve your proposed legislation. If your Bill should be enacted into law, ultimately the people will be pinched by the yoke and they will blame the perpetrator. If the people and the doctors of your own state should choose to follow your proposals, I would have nothing to say. But I am wondering if you realize the United States reaches from ocean to ocean and that the respective states sprawling across the continent present variable and often distinct social, economic, political and even medical problems. From a medical viewpoint, after public health does its job, the solution of these problems belongs to these respective states. Speaking for Oklahoma, we will come up to the draft board as physically fit as your New Yorkers, we will be more typically American, we will last as long in battle and be a little quicker on the trigger. For twenty years I have visited New York two to three times annually. How many times have you crossed the Mississippi to see us? Do you know what we need? We love you and we enjoy fighting for you and we expect to continue putting food on your tables but please leave us freedom in these essential pursuits. Here's hoping you will have Oklahoma turkeys and Kansas City steaks for Thanksgiving and Christmas.

Now that we do definitely disagree on this controversial problem, why not set up the credentials for our individual opinions. I should not venture to be so personal if the

issue were not so ponderous. The following I have taken from Who's Who in America, which no doubt had your approval.

"Wagner, Robert Ferdinand: B. S. Degree from the College City of New York, 1898; LL. B., New York Law School, 1900; widower; one son Robert F., Jr. Practiced at New York City; member New York Assembly, 1905-08, Senate, 1909-18; Chm., New York State Factory Investigating Commission, 1911; Lt. Gov. of New York, 1914; Justice Supreme Court of New York, 1st District, 1919-26; assigned to Appellate Division 1st Department, 1924 (resigned); member U. S. Senate since 1927; Chairman, Senate Committee on Banking and Currency. Democratic leader, New York Constitutional Convention, 1938. Introduced National Industrial Recovery Act, Social Security Act, National Labor Relations Act, Railway Pension Law, U. S. Housing Act of 1937, and other social and economical legislation in Senate."

I am a native of Kentucky and I grew up in a small town. Eight years of my life were spent in preparation for the practice of medicine, three of these school years on borrowed money. Compared with the present federal subsidies for medical students, borrowing was good fertilizer for the growth of character. I am glad that I borrowed from Uncle Bob instead of begging from Uncle Sam. In a middle state, east of the Mississippi, I was temporarily a doctor on horse back 25 miles from a railroad. For six years I was a horse and buggy doctor on the plains, replacing my intern service by practice in dugouts, sod houses and prairie shacks. I have been in general practice in a modern small city and later in highly specialized practice with a private sanatorium. One year of medical studies in Europe; twenty years teaching medicine in the University of Oklahoma; three years as Dean of the same school. During my Deanship I was Superintendent of the University Hospital and the Crippled Children's Hospital, both having active outpatient departments serving the whole state.

I have been President of the local Tuberculosis Society and head of a free tuberculosis dispensary for 27 years and a member of the National Tuberculosis Association Board for a corresponding period of time. I have been an humble student of the history of medicine during my professional career and have tried to correlate and integrate the various phases of medical progress during the past 2,500 years.

Through these various interests and intimate contacts with doctors, medical students and patients of all classes, I have a feeling that I may know something about what the American people want and what they need in the way of medical service and what a radical change may do to the high purposes

which now dominate the profession. Though this may be difficult for you to understand, I can truthfully say that with few exceptions, doctors are interested in the welfare of the people and not in their own promotion.

Please leave my medicine on this tripod, the patient-doctor-and God. The patient and the doctor usually find their relationship mutually helpful. When they fail in this they are free to make changes or adjustments. God seems to be interested in both and exacts no accounting except reasonable skill and the exercise of conscience, and fortunately he presents no interminable, incomprehensible blanks to be filled out in triplicate.

This lengthy discussion has been long in my system, but I could never presume to trouble you with it until your recent communication provoked this response. Without malice toward you, I am opposed to your program because I am in favor of charity toward all. In closing, may I urge you to study the history of medicine in the United States and try to realize that you and I would not be indulging in this controversy if medicine in the United States had not kept abreast of scientific and mechanistic development in other fields. Our old age problem is pyramid-

ing because American medicine has been good enough to double our longevity in the short period of our national existence. Today if it were not for preventive medicine and sanitary engineering (also medical), the vultures would be roosting on the dome of the Capitol and defiling the most beautiful city in the world with filthy excrement resulting from the reconverted carrion picked from the bones of congressmen, bureaucrats and government employees, who if they are not careful may do to us what Bismarck did to Germany and swing the medical pendulum back for a long and annulling period of decline.

Medical science can never click with the clock, medical progress can never successfully stem the obstacles arising through directives and senseless paper work — even the willing spirit may grow weak under the domination of flesh which is not a part of its own carnal habitat.

Respectfully and humbly submitted for your consideration.

Sincerely,

Lewis J. Moorman, M.D.

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THE PRESIDENT'S PAGE

The District Councilor's Meetings that have been held, we feel, have been very worthwhile. The attendance, in number and interest shown, was gratifying and inspiring to the officials and makes the appraisal of interest for continued activity, on the part of the Speaker's Bureau.

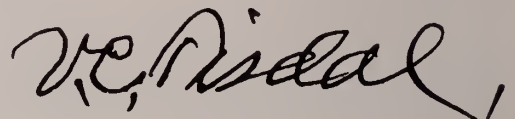
We are pleased to announce that the State Board of Health has adopted a policy for governing the general outline of the Board with special emphasis on securing the cooperation and support of the doctors as well as the public. The policies adopted by the board, in brief, are as follows: In addition to its duties in appointing a commissioner and promulgating rules and regulations under powers delegated by the legislature, the Board of Health should act in an advisory capacity to the Commissioner in formulating an energetic, active program in all departments with the dominating activity centered on public relations, education being a prime factor in the dissemination of the program to the public. The basic laws and regulations now existing and in operation by the Commissioner of Health have been reviewed and must, of necessity, serve as an outline of the program to be pursued. The policies must conform to the State laws governing public health and each department should be imbued with the importance of educating the public as to the problems and the benefits intended in their proper administration. The Board of Health should use its influence to establish full-time County Health Units; to aid in surveying the needs and acquainting the officials of the Counties with the Public Health Program, and in formulating a flexible program of Public Health that meets the needs and demands of the people in each County.

Such a program should provide that the County Health Unit work in harmony and cooperation with the County Medical Society. For maximum results the County Medical Society for its part must be cooperative, must not restrict the general principles or hamper the administration of the laws of public health and will be expected to cooperate with the County Health Unit in all the program of preventive medicine, properly discharging its duties regarding quarantine. The State Board of Health should further lend its influence to interest the doctors of the County Medical Society as to their responsibility of properly immunizing infants and pre-school age children. This should eliminate the controversial issue of infringement of the Public Health Program of the practice of the family physician.

In counties with no organized Health Unit an educational program of sanitation and preventive medicine should be made available to every community, giving the people information regarding the responsibility of being immunized; the importance of oral hygiene, food sanitation, property sanitation, milk sanitation and nutrition. In other words, a general program should be arranged, particularly in the schools.

The formation of a Public Health Committee should be encouraged in every county.

The above is a brief outline of the general policy which was adopted by the Board of Health at the first meeting after organizing on July 8, 1945. This meeting carries a historical meaning in that it is the first action by a Board of Health in our great commonwealth. The degree of cooperation put forth by the Allied Medical Profession and interest manifested through education in our schools and every other organization that has for its public the unnecessary death toll from preventive causes must, of necessity, be the goal.



President.



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EDITORIALS

A STRANGE PARADOX

Strange as it may seem to the Lord, here on earth, we face the planned killing of our physically fit while there are not enough people to adequately support the millions who fight. The work of the world is waning while the blood of our youth laves the soil and the sea around the globe. We have hung up the shovel and the hoe, we have converted the plow share into implements of war. We have deserted the shop and the school in order to kill.

Those who may say this is only a wild generalization should look carefully into the present situation and think seriously of future possibilities. There is not only a shortage of man power, where physical effort is required but it is equally obvious in every calling and professions where special skills and brains are needed.

With reference to the latter, a good look at the medical profession will serve as an illustration. Even before war was declared there was a dearth of well trained men in certain highly specialized fields and the approach to success in all phases of medicine had become increasingly difficult, ever exacting more time, effort and money. To reach

the threshold of the medical school required more thought and study than the completed medical education a generation ago. Certification in the specialties entailed an additional period of three to five years.

Though medical education has been streamlined for the sake of quantity at the cost of quality, the matter of medical service both civilian and military becomes more acute. This is true even in our own land where libraries, museums and other educational facilities have not been destroyed by bombing. Even so, it is going to be difficult for us to meet the higher levels demanded by scientific advances with the limited mill run from our medical schools even under the present acceleration program. If we succeed in meeting the quantity needs it will take a long time to make up what we are losing in quality. Perhaps new ways may be found to make up the losses. The stupendous task confronting the medical profession may be partially appreciated by a study of the final report on 21,029 questionnaires dealing with postgraduate wishes of medical officers.¹ The almost universal desire for postgraduate work and the large number desiring long courses will delay long needed relief for over-

worked civilian doctors long after the war ends. As in anticipation of war, now in anticipation of peace, the doctors are looking ahead.

Finally it is safe to say that even though we make the most of our educational facilities including all possible new planning, much promising material will go to waste for want of educational opportunities. In closing we cannot resist the temptation to hope that the federal government will not further hamper scientific progress by establishing a system of regimented medicine. Working one-third the way around the clock can never meet the needs of medical science and at this time it would be fatal to cut the average doctors day in half. The humiliation of working on a tradesmans schedule and the irritation of mandatory paper work would leave medicine devoid of its most cherished quality — humanism.

1. Journal A.M.A., Vol. 128, No. 2, May 12, 1945.

PUBLIC HEALTH—A GRAVE RESPONSIBILITY

The summary of our health legislation for 1945 appearing in the June issue of the Journal should impress every reader with the heavy responsibility this legislation places upon the doctors and the people of a forward-looking young State. Every member of the State Medical Association should try to understand the spirit and the letter of these new health laws and should strive to see that they are honestly and judiciously applied. With our knowledge of medicine, its evolution, and its ever changing application to human needs, we can give to the people of Oklahoma a health service with its roots in our own soil and its fruits bearing the flavor of our own toil. To the people of this State and Nation, let us demonstrate through this legislation and personal initiative that charity begins at home and that we need none of the Wagner Bill's pernicious medical proposals. In view of our great responsibility under the enabling provisions now before us, it seems fitting to turn to one of our masters in the field of creative and applied medical science and particularly in the wide realm of public health.

On his 80th birthday (April 9, 1930), while modestly acquiescing in the planned celebration tendered him in Washington, D. C., William Henry Welch responded to the world's deafening applause in charming self-effacement, closing his remarks with these words of wisdom:

"While public health is the foundation of the happiness and prosperity of the people and its promotion is recognized as an important function of government, how wide is the

gap between what is achieved and what might be realized, how inadequate is the understanding of the public concerning the means adopted to secure the best results, how small the attractions offered to those entering or who might desire to enter careers in public health through lack of suitable financial recompense, of security of tenure of office, of opportunities for promotion, of standards for eligibility based upon special training and experience, and of funds made available for the public promotion of health. Something of the lack of adjustment of the average man to rapidly changing social, economic, and political conditions of our complicated modern civilization may be reflected in a certain temporary maladjustment between curative medicine and preventive medicine, which should stand in harmonious relations.

"As my immediate and, doubtless, final professorial interest is on the humanistic side of medicine, I may, in closing, be permitted to emphasize the attractions and importance of studies in the history of medicine and of science. We physicians apply the word "Humanism" to a period and to a spirit which released the mind from thralldom to authority and contributed mightily not merely to the study of antiquity but to the study of nature and of man, leading logically and rapidly to the cultivation of experimental science, between which and humanism as we understand and use the word, there is no incompatibility whatever.

"While nothing can be more hazardous than to attempt to predict the directions of future discovery and progress in the biological and medical sciences, it requires no prophetic gift to be confident that with the widening of the boundaries of knowledge will come increased power to relieve human suffering, to control disease, to improve health and thereby add to the sum of human happiness and well-being."

President Herbert Hoover who was serving as Honorary President of the Committees of Celebration, a scientist and a great humanitarian in his own right, added these significant words to the universal acclaim accorded the accomplished octogenarian.²

"The many years that I have been honored with Dr. Welch's friendship make it a privilege to join in this day of tribute to him by his friends and by the great scientific societies of our country and of the whole world. Dr. Welch has reached his eightieth year and a whole nation joins in good wishes to him.

"Dr Welch is our greatest statesman in the field of public health, and his public service to the nation well warrants our appreciation of him. With profound knowledge, wide experience and skill in dealing with men, sound

judgment and a vision of the future, he has been a great asset to this nation, and we may fortunately hope that he will continue for many years to bless mankind with his invaluable leadership.

"Our age is marked by two tendencies, the democratic and the scientific. In Dr. Welch and his work we find an expression of the best in both tendencies. He not only represents the spirit of pure science but constantly sees and seizes opportunities to direct its results into the service of human kind.

". . . No valuable change in everyday practice of any of the great arts has ever been made that was not preceded by the accretion of basic truths through ardent and painstaking research. This sequence that precedes effective action in medicine is equally important in every field of progress in the modern world. It is not the method of stirred public emotions, with its drama of headlines; it is rather the quiet, patient, powerful and sure method of nature herself, of which Dr. Welch has been the master.

"Dr. Welch has happily combined in his character and intellect the love of truth and the patient experimental habit of the pure scientist, with the ingenuity of the inventor and the organizing vision and energy of the promoter of sound enterprise — and combines all these things with a worldly wisdom and gracious charm that have made him a leader amongst men.

"When we have said all of these things in tribute to his scientific knowledge, his great influence in education and public health, we have one more thing we may say that transcends them all. That is, that he has contributed more than any other American in the relief of suffering and pain in our generation and for all generations to come.

"I know that I express the affection of our countrymen and the esteem of his profession in every country when I convey to him their wishes for many years of continued happiness."

Seeking a bit of reflected glory we call attention to the fact that our own Robert Hickman Riley (University of Oklahoma School of Medicine, 1913) trained and worked under Welch and largely through his influence became Chairman and Director of the Maryland State Board of Health, a position which he still holds.

1. William Henry Welch, at 80. Edited by Victor O. Freeburg. Published for the Committee on the Celebration of the Eightieth Birthday of Doctor Welch. Milbank Memorial Fund, New York

2. Herbert Hoover, President of the United States. At the Ceremonies in Washington. William Henry Welch, at 80. Edited by Victor O. Freeburg. pp. 34-35.

A NEW WAGNER-MURRAY-DINGELL BILL*

On May 24, 1945, Senator Wagner, for himself and Senator Murray introduced a new bill—No. 1050—amending the Social Security Act. On the same day, Congressman Dingell introduced an identical bill in the House of Representatives.

Mr. Wagner states that this bill includes six provisions which will make available basic health services to all the people wherever they live and whatever their income.

First, a program of Federal grants and loans to states for the construction of needed hospitals (an estimated total of \$950,000,-000.00).

Second, the present Federal grants-in-aid to the State for public health services are broadened and increased to speed up the progress of preventive medicine and community-wide health services.

Third, the community-wide maternal and child health and welfare services, aided by Federal grants to the States, are similarly broadened and strengthened.

Fourth, health insurance is made available to 135,000,000 persons.

Fifth, the funds are set aside from the social insurance contributions to aid in the rehabilitation of persons who are disabled.

Sixth, grants-in-aid are provided from social insurance funds to non-profit institutions engaging in research or in professional education.

In the language of Mr. Wagner, this health program sounds very wonderful if the huge sums needed for this scheme were as easy to raise, but the bill provides that pay-roll taxes totaling 8 per cent, for the employee 4 per cent, while self-employed persons pay 5 per cent of income up to \$3,600.

Thirty-seven and one-half per cent of all payroll taxes are to be placed in a "Personal Health Services Account," which is estimated will total \$3,142,000,000 annually. Out of this fund, the Federal Government through the Surgeon General of the Public Health Service, is to pay all costs of general medicine, special medicine, general dental, special dental and home nursing care and for all laboratory and hospitalization costs for all social security and beneficiaries and their dependents.

Fifteen million additional people—farm workers, domestics, self-employed, etc.—are to become subject to the provisions of the law, pay taxes and receive benefits.

In comparison to the previous legislation (S 1161-1943), 37½ per cent instead of the 25 per cent of the total Social Security Fund is allocated for Health Services, and in addition to medical care, laboratory services and

*Reprinted from The Bulletin of the Pottawatomie County Medical Society Vol. VIII, No. 7, July, 1945.

hospitalization, the new bill provides for dental care and home nursing services.

In an attempt to overcome the chief objection raised by the medical profession, Senator Wagner stated that, "he believed in Free Enterprise; that this proposal was not socialized medicine; that it provided for the patient choosing his physician, and the doctor choosing his patients." These statements are only a subterfuge and are definitely misleading and the proposals of the bill do not confirm them and it is impossible to create such a fund and establish the machinery to provide this kind of service without destroying the private practice of medicine in the United States.

The physicians of the United States, all 100,000 of them, can present a solid front—stand united—and preserve our system of private practice and our highest level of health or we can surrender and sacrifice all independence and initiative by placing the distribution of medical care in the hands of politicians and becoming subordinate and subservient to the bureaucrats!

It is essential that every physician fully understand the provisions and the implications of this bill, and he should write his Senators, both of them, and his Congressman, secure a copy of these bills and read them carefully!

Also, it is important that every physician aid in the efforts to clarify this issue for the public—both his patients and his friends.

The attitude of the Administration in Washington will be governed in its recommendations by what will have the approval of the voters. We must win this fight for the people, by doing our part NOW!

NOT THE MERE HIRELING OF BUREAUCRACY

Now that we again face the threat of the Wagner Bill, it is a good time to quote from "The Morning Visit" by Oliver Wendell Holmes:

And last, not least, in each perplexing case,
Learn the sweet magic of a cheerful face,
Not always smiling—but at least serene;
When grief and anguish cloud the anxious scene,

Each look, each movement, every word and tone

Should tell the patient you are all his own,
Not the mere hireling—purchased to attend
But the warm, ready, self-forgetting friend,
Whose genial visit in itself combines

The best of tonics, cordials, anodynes,
Such is the visit that from day to day

Sheds o'er my chambers its benignant ray.

I give him health who never cared to claim
Her babbling homage from the tongue of Fame.

Unmoved by praise, he stands by all
confessed

The truest, noblest, wisest, kindest, best.

MONOTONOUS

A current communication from the author of the Wagner Bill addressed to the Journal seeking favorable consideration for the proposed legislation inspired the following comment.

We grow weary standing in armor ready to fight the ever recurring attack upon American medicine. Living behind steel plate and sleeping in a coat of mail is irritating but doctors can take a lot of punishment, not for political reward, but for the sake of their people.

How we would like to plunge this red hot piece of political propaganda into a flood of cold common sense and be done with it forever! May we look to the people for the needed common sense? Yes, unless it is restrained by the coercion of already existing regimentation. In other words, many political blocs are counting heads not wholly committed to the adopted course but reluctantly acquiescing because not wholly free to express individual opinion. May God restore our lost freedom and protect us from further bondage.

Anatomical Phenomena of Pneumonia as Seen By Bartlett 100 Years Ago

The first inquiry that presents itself relates to the local lesion which constitutes, anatomically, the disease. What, and how much do we know of this lesion?—of its seat, its phenomena, its nature? What are the foundations, the nature, the extent, and the degree of certainty, of our knowledge of these things? The answer to these questions is at hand; it is definite, and it is sufficiently satisfactory. We know that with the commencement of the inflammation, the portion of lung which is the seat of this morbid action, becomes of a deeper red color than it has in health, with a livid or violet tinge; that its specific gravity is increased, from an undue accumulation of blood in its vessels, and a corresponding diminution of air in its air-cells; that it has lost, in a great degree, its spongy and elastic feel, and is more doughy and solid to the touch; that it is less tough, and more friable; and that when cut or torn, a large quantity of reddish, turbid, and brothy fluid flows from the surfaces. We know that except in a very small number of cases, in which this stage of engorgement continues until the subsidence of the disease, in the course, generally, of from two to five or six days, the diseased lung undergoes other, and still more striking changes. Its specific gravity is still further increased, so that it is a heavy and solid as liver; it contains no air and does not crepitate; its air-cells are obliterated; its surfaces, when cut or torn, are of a deep red color, often mottled, or marbled; a reddish, thick, opaque, and semi-purulent fluid flows from them in moderate quantity, and they are crowded with a multitude of small, red, slightly flattened granulations.—*Elisha Bartlett, An Inquiry into the Degree of Certainty in Medicine*. 1948.

ASSOCIATION ACTIVITIES

RADIO BROADCAST HELD ON JUNE 30

On Saturday, June 30, Governor Kerr turned over his regular monthly program to the medical profession for the purpose of explaining the State Board of Health. The following program was broadcast after Governor Kerr's initial remarks concerning public health program for the people of the state.

DR. LOWRY: Thank you, Governor Kerr. Ladies and gentlemen: The medical profession is more conscious than any other group of the benefits which a progressive health program will bring to the people of Oklahoma. We have in the studio today some members of that profession whom we have asked to participate in the round-table discussion of this subject.

Those present are: Dr. C. R. Rountree, President of the newly appointed Oklahoma State Board of Health and retiring president of the Oklahoma State Medical Association; Dr. V. C. Tisdal, member of the Oklahoma State Board of Health and President of the Oklahoma State Medical Association; Mr. Paul Fesler, Executive Secretary of the Oklahoma State Medical Association and Administrator of the University Hospital and Oklahoma Hospital for Crippled Children; and Dr. Grady Mathews, Oklahoma's Commissioner of Health.

Dr. Rountree, will you please give us a brief history of its development, and also briefly summarize the health bills which were passed by the Twentieth Session of the Oklahoma Legislature?

DR. ROUNTREE: The present administration through Governor Kerr, sponsored this legislation. The members of the 20th Legislature, the Public Policy Committee of the Oklahoma State Medical Association and other interested agencies enacted this aggressive public health legislation. A total of 17 bills were passed. The first and most important of these bills was the establishment of the State Board of Health. Other laws passed include:

A law requiring examination for syphilis before a marriage license is issued.

A law defining venereal disease as communicable and providing quarantine.

A law providing for the creation and financing of County Health Departments.

A law requiring the inspection and regulation of frozen food lockers.

A law authorizing the State Health Commissioner to accept federal aid.

A law providing that all pregnant women shall have a serological blood test for syphilis, and defining the duties of the attending physician.

A law providing for the inspection and labeling of bedding.

A law giving the State Health Department the responsibility of the inspection, regulation and licensing of hospitals, sanatoria and nursing homes.

A law providing for a survey to be made of existing hospital facilities.

A law appropriating for the next two years \$372,000.00 for the maintenance and establishment of County Health Departments.

A law providing for a state-wide hospital plan, creating an advisory council to vitalize the provisions of this act and making provisions for sharing in Federal grants for the construction of hospitals in the State.

Dr. Lowry, this program is the most comprehensive health program to be yet adopted, and is an attempt to bring adequate medical and hospital care within the reach of every citizen of Oklahoma.

DR. LOWRY: Thank you, Dr. Rountree. Dr. Tisdal, it would be fitting that you tell us your plans for the medical profession to help to carry out and develop this program.

DR. TISDAL: The existing emergency is well known. For every soldier killed in battle there are 17 people at home who die from causes which can be prevented. Our Governor, being aware of this condition, lead the initiation of a program to meet the emergency, enlisting the support of the 20th Legislature, enacting legislation that this program is identifying. It has been, is now, and will continue to be the policy of the Oklahoma State Medical Association to lend its effort to render service which will help relieve such existing conditions. In the past, the doctors have confronted and conquered seemingly unsurmountable conditions and this is being demonstrated by our medical corps in the Armed Services. The home front is capable if properly apprised of its responsibility to accomplish a like service, and through the different committees of the Oklahoma State Medical Association, namely the Cancer, Tuberculosis, Child Welfare and Public Health Committees, this service can be extended. It is our sincere desire to cooperate with, and be advisory to every organization which has for its purpose the preservation of the health of the people. Through the common school, the high school, the higher educational institutions and the State Educational Association with the Medical School leading the fight, also through the civic clubs, the churches, commercial clubs and ladies organizations, we have the greatest opportunity to accomplish this purpose. With these comments we, the membership of the Oklahoma State Medical Association do most energetically pledge our support to the Oklahoma State Health Department in helping to carry through such a needed program.

DR. LOWRY: Thank you, Dr. Tisdal. Mr. Fesler, as a hospital administrator, you are interested in providing adequate hospital care for the people of Oklahoma. May I ask you if this program makes any provision or plans for such services.

MR. FESLER: Dr. Lowry, surveys shows that Oklahoma needs hundreds of additional hospital beds. In 20 counties there are no hospitals, and in a number of other counties there is an inadequate number of hospital beds. The last legislature developed a plan which should ultimately remedy this serious situation. The University Hospital and the Oklahoma Hospital for Crippled Children will serve as a base hospital. It is hoped that district hospitals will be developed in strategic centers. Under the constitution, the base and district hospitals must be state institutions. These institutions will be supervised by the faculty of the School of Medicine of the University of Oklahoma, supplemented by local physicians. This arrangement should insure the best type of medical care. The plan from there on is a local responsibility. After a complete survey of all hospital and medical facilities by the State Health Department, rural hospitals and health centers will be recommended in areas of the State where they are most needed. These hospitals and health centers will be controlled locally. This plan will provide for the care of all types of illness including tuberculosis and chronic diseases. This Oklahoma hospital plan, as developed by our Governor and the Legislature, is in line with Federal Legislation now pending. This legislation provides for matching local funds for the construction of such facilities, and, as Dr. Rountree has said, it should bring the best hospital and medical service within range of every citizen regardless of his social or economic status. The Oklahoma plan has been used as a model by National standardizing

agencies. This is a long range plan and the success will depend on the continued interests of the local community.

DR. LOWRY: Thank you, Mr. Fesler. Dr. Mathews, it has been said the newly established and appointed Oklahoma State Board of Health is the most important of these health bills. As Oklahoma's Commissioner of Health, please tell us just what will be the functions of this Board, and how do you think it will improve the services of the State Department of Health.

DR. MATHEWS: The creation of a Board of Health will, in my opinion, do more to strengthen the cause of Public Health in Oklahoma than all previous legislation. This Board will determine certain broad policies which will direct the course of the department in the future. I am convinced that the creation of this Board will not only promote the Public Health movement in Oklahoma but will improve and make more effective the work of the Department. It is rather difficult to mention all the duties which will fall to this Board, however, there are certain general ones which I might mention.

1. Appoint a commissioner of Health.
2. Make rules and regulations for vitalizing all laws pertaining to public health in Oklahoma.
3. Formulate certain broad and general policies for the operation of the health department.
4. Recommend needed legislation.
5. In general, the Board will give moral support to the Commissioner in the health program and collectively and as individuals interpret to the public the intent of the health department's day to day program which is in reality the Board's program.

I believe in Public Health, I make my living as an advocate of Public Health, and I am convinced that it is possible to have healthier people, healthier homes, and communities, which will make a healthier state and nation. This objective is not in the realm of idle dreams but can become a reality when the public is informed and educated in the principles of better personal and community health and have learned to apply these principles to their daily living.

DR. LOWRY: Thank you, Dr. Mathews.

Gentlemen, we appreciate your well correlated discussion of this health program. We are all aware that in order to carry on this program, we will need more doctors, more nurses, and more trained medical assistants. The Twentieth Legislature provided for these needs by appropriating \$1,680,000 for a building program for the School of Medicine and its hospitals. This will expand the facilities both for teaching and for taking care of the indigent sick of the State. We will train more and better doctors to improve the medical and hospital care of the people of Oklahoma. Also, it is the plan of the University of Oklahoma in cooperation with the School of Medicine to develop a School of Public Health to train sanitary engineers, public health nurses, and public health doctors; also a school of laboratory and x-ray technicians and dietitians, which we now have. Governor Kerr, we are grateful to you and the members of the

Oklahoma Legislature for making this progressive health program possible, and we appreciate the privilege of participating in this discussion. Thank you.

ENTHUSIASTIC LAY AND MEDICAL MEETINGS HELD AT ENID FOR COUNCILOR DISTRICT 3

On June 13, under the supervision of Dr. John Walker, Enid, Secretary of the Garfield County Medical Society, and Dr. C. E. Northeutt, Ponca City, Councilor for District No. 3, and Dr. Paul Champlin, Enid, an afternoon lay meeting and an evening medical meeting and dinner were arranged in Enid. Dr. V. C. Tisdal, Elk City, President of the Oklahoma State Medical Association, furnished the program for both meetings which included Mr. Paul Fesler, Executive Secretary of the Association, Dr. Ed N. Smith, Oklahoma City, Dr. Champlin of Enid, Dr. Richard M. Burke, Oklahoma City, Major J. A. Cowan, U.S.P.H.S., Dr. Grady F. Mathews, State Health Commissioner, Dr. John Burton, Oklahoma City and Dr. A. S. Risser of Blackwell.

The lay meeting was announced for 2 p.m. on the afternoon of June 13 in the ballroom of the Youngblood Hotel. The audience consisted of 27. Although the audience was small, great interest was manifested and many questions were asked the speakers at the end of the program. Dr. Northeutt, Councilor, opened the afternoon meeting by explaining the purpose of carrying the medical education over the state. He stated that it was the aim of the medical profession to better educate the public along these lines in order that they would be more capable of helping themselves.

Mr. Paul Fesler, in discussing tuberculosis, stated that he had found that a great majority of patients were sent to tuberculosis sanatoria at a time when it was practically impossible for the doctors to give the patient the benefit of their knowledge, equipment and experience. This was caused because the people had not been educated to the fact that it was necessary to come for treatment while the disease was in its early stages. The important thing is for the medical profession to educate the people to protect themselves. Mr. Fesler also outlined the possibilities of tuberculosis in parts of the body other than the lungs.

Dr. V. C. Tisdal was introduced and told the audience that the medical profession appreciated the interest shown by the public in obtaining education along medical lines and said that it was the purpose of the State Association to carry that education to them.

Dr. Paul Champlin of Enid, speaking as Chairman of the Cancer Committee, discussed the program of the committee and the Cancer Drive for funds.

Dr. Ed N. Smith, Committee on Maternity and Infancy, spoke to the group on Maternity Mortality. He stressed the fact that many things could be done to

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prevent the causes of death in this respect and to save many lives. He further explained that the causes of death were preventable and the important thing was to get the message across to the people that it was all-important that a physician be consulted in order to prevent the cause. Dr. Smith said that an extensive educational program was being conducted by the doctors and that the message could be further carried by the people themselves.

Dr. Northcutt was given the floor and spoke on the Blue Cross Plan. He outlined the plan and told the audience of the benefits to them. The Oklahoma Physicians Plan as sponsored by the Association was also explained.

At 6 p.m., dinner was served in the Enid Room of the Youngblood Hotel to the medical group. Thirty members were present. The program was opened by Dr. Northcutt who introduced Dr. Tisdal. Dr. Tisdal explained the Four Point Program of the Association and told of the endeavors of the Association to educate the public. He outlined the plans for Fall meetings of County Societies and urged the members to call for a speaker from the Speakers Bureau of the Association. Dr. Tisdal stated that it was the responsibility of the Association to carry the program out of the state to the members.

Dr. Richard M. Burke, Oklahoma City, was introduced and told of the extensive tuberculosis program being carried on over the state; the use of the portable x-ray units in reaching the contacts. Dr. Burke also gave the statistics on hospital beds for tuberculosis and explained how the last legislation passed would help this situation.

Major J. A. Cowan, U. S. P. H. S., was given the floor and discussed "Venereal Disease Control." Dr. Cowan cited the past legislation passed with regard to venereal diseases and explained the benefits to the people. The rapid treatment clinics in the state were discussed and Dr. Cowan stated that with diligent care and attention, venereal disease could be stamped out within the next twenty-five years.

Dr. Grady Mathews, State Health Commissioner, next

said a few words regarding the joint responsibility to the people of the medical profession and the health units.

Dr. Tisdal then called upon Dr. John Burton, Oklahoma City, to explain the Oklahoma Physicians Plan. Dr. Burton said that the doctors are living in changing times and must adapt themselves to the times. He explained that the Plan was one method of combating the problem of socialized medicine and caring for the catastrophic illnesses of the people. The Plan, Dr. Burton stated, would not be put into a County until the County Society approved and supported it.

Mr. Paul Fesler, Executive Secretary, discussed the medical school appropriation and the hospital license laws which provide that every hospital in the State must meet certain standards. Mr. Fesler then explained and discussed the Hill Burton Bill and the new Wagner Bill—S 1050, urging the members to get in touch with their congressmen and representatives, telling them that the medical profession is *for* the Hill Burton Bill and *against* the Senate Bill 1050.

Dr. A. S. Risser, Blackwell, was called upon to close the program with a talk on "The Responsibility of the Medical Profession to the Laity." Dr. Risser said that the responsibility could be summed up in one word—"Information." He stressed the fact that it was the medical profession's place to inform the public, teach them the facts about the diseases and their prevention. He stated that the science of medicine is hundreds of years ahead of its application. Not only should the members write to their congressmen but they should be missionaries in their own offices by getting the message across to the patient. He stressed the responsibility of those at home to the men who have gone to War.

Dr. Tisdal welcomed Major Neiss and Captain Goff who were guests from the Enid Army Air Base.

Dr. Paul Champlin expressed appreciation to the Association and Dr. Tisdal for the program and stated that the enthusiasm shown by Dr. Tisdal was infectious.

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DISTRICT 2 COUNCILOR MEETING AT HOBART WELL ATTENDED

A group of 70 physicians, their wives and guests were entertained at dinner in Hobart preceding the two meetings held there on the evening of June 19. The dinner was held at Al Roy Cafe and the medical meeting was held in the same place, the lay meeting being held in the basement of the library. Guests at the dinner were introduced by Dr. J. Wm. Finch, Councilor of District No. 2.

There were 35 present at the lay meeting and 25 physicians present at the medical meeting. Wide publicity was given to the meetings through the cooperation of the Hobart Democrat Chief, the Hobart Star Review, and the Mt. View News. Dr. Finch, as Councilor, was enthusiastic in his efforts to urge the membership of the District and their guests to attend. Dr. Wm. Bernell made arrangements for the excellent dinner that was served.

Dr. V. C. Tisdal, President of the State Association, acted as Chairman of the Medical meeting and Mr. Paul Fesler, Executive Secretary of the Association was Chairman of the Public Meeting. Speakers included: Dr. Clinton Gallaher, Shawnee, who acted as spokesman for Dr. Tisdal who was suffering from laryngitis; Dr. Paul Champlin, Enid; Dr. Ed N. Smith, Oklahoma City; Dr. J. T. Bell, State Health Department; Dr. Richard Burke, Oklahoma City; Mr. N. D. Helland of the Blue Cross Plau, Tulsa; and Dr. A. S. Risser, Blackwell.

Dr. Gallaher explained that through the efforts, planning and execution of the Program of the Association, the members were being brought closer together, and stressed the fact that it is essential that all members know each other and work together. At this point Dr. Gallaher called the attention of the group to the years of faithful service and untiring efforts of Dr. H. K. Speed, Sayre, Dr. A. H. Bungardt, Cordell, Dr. J. M. Bonham, Hobart and Dr. McLain Rogers, Clinton. Next, the State Board of Health and the health laws passed in the last legislature were explained and outlined.

Dr. Paul Champlin was called upon to give the aims and objects of the Cancer Committee. He stated that in the past, the education of the people was the principal part of the program but that this year, with the work of noted laymen, a drive for funds was most successful and the possibility of carrying on a more extensive program was now evident. He further stated that the money raised would be devoted to research, tumor clinics and service to the incurable.

Dr. Ed N. Smith, of the Committee on Maternity and Infancy, next spoke on Maternity Mortality. Dr. Smith told of the questionnaires that had been sent to the doctors in an effort to ascertain the causes of death from child-birth and said that the doctors had benefited greatly from the results of this procedure. He further stated that the logical approach to the problems of maternal and child care is the extensive education of the youth in the highschools, and womens clubs.

Dr. Gallaher urged the members to call on the Speakers Bureau of the Association for speakers for the fall meetings of their Societies. He then called upon Dr. J. T. Bell, Oklahoma City, of the State Health Department.

Dr. Bell discussed public health and defined it as preventive medicine. He also discussed medical and sanitation measures which the state health program is offering.

Dr. Richard Burke, Oklahoma City, was next called

upon to discuss the tuberculosis situation. Dr. Burke pointed out the necessity of reaching the contacts of the disease and told of the portable x-ray units that were going over the state obtaining chest x-rays. He said that the program should be expanded to x-ray everyone in the State.

Mr. N. D. Helland, Tulsa, Blue Cross Representative, gave an analysis of the Blue Cross Plan and the Oklahoma Physicians Plan, explaining that the plans caused no interference with private practice. Mr. Helland compared the paying of hospital and doctor bills through the plans to the paying of utility bills.

Dr. A. S. Risser, Blackwell, was next introduced and spoke on "The Responsibility of the Medical Profession to the Laity." Dr. Risser stated that the doctors were not doing enough missionary work with the patients, that it was imperative that the people be educated. Dr. Risser then stressed the importance of refresher courses for the men who come back from the War. He added, "I am not forgetting the credit that the home front doctors should have, we who have remained at home have taken care of, in great numbers, casualties, deaths, children and aged."

In speaking of the new Wagner-Murray-Dingell Bill, S. 1050, Dr. Risser stated that this would determine whether or not this will remain a free country. He urged the doctors to tell the people the truth and let them write to their congressmen and representatives.

The meeting was closed by Dr. V. C. Tisdal who expressed appreciation for the fine attendance and the interest shown in the meetings.

Superlative

"A geologist," in the words of one of my friends—anatomist, physician, philosopher, poet, and wit—"hands to his physiological friend, a particle broken from a fossil tooth, and requires the nature, size habits, food, date, of the behemoth, the megalosaurus, the palaeotherium that chewed upon it. The physiologist grinds a speck of it down to a translucent lamina, saturates this shaving with the light from a little concave mirror, screws his inexorable lenses to their focus, and extorts a truth which nature had buried beneath the deluge and blotted with the night of uncounted ages."—*Elisha Bartlett. An Inquiry into the Degree of Certainty in Medicine. 1848.*

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MEETINGS AT DUNCAN, DURANT, HUGO AND McALESTER TO BE REPORTED IN NEXT ISSUE

Due to lack of space in this issue of the Journal, the full report of the following meetings will appear in the next issue of the Journal.

Duncan—June 25—District 5, J. L. Patterson, M.D. Councilor.

Durant—June 26—District 10, John A. Haynie, M.D., Councilor.

Hugo—June 27—District 10, John A. Haynie, M.D. Councilor.

McAlester—June 28—District 9, Earl M. Woodson, M.D. Councilor.

These meetings were well attended and great cooperation was shown on the part of the Councilors and members.

POSTGRADUATE INSTRUCTION

On August 17 the first circuit in Surgical Diagnosis, under the instructorship of Dr. Patrick Wu, will be completed. The entire Postgraduate Committee is more than enthusiastic. The attendance at each teaching center has been excellent. The physicians throughout the circuit are unanimous in their praise of Doctor Wu, the subject matter of his lectures and his teaching ability.

During the latter part of August, Doctor Wu will visit Eastern Medical Centers and Surgical Clinics where he will observe and obtain the latest material for use in his Oklahoma postgraduate teaching.

The circuit beginning September 17 will include the following centers: Chickasha, Pauls Valley, Norman, Shawnee and Wewoka. Doctors in these centers are urged to be prompt in taking advantage of the opportunity of receiving this course.

DEAR DOCTOR

If you are interested in "putting out the fire that is raging now" rather than in building an edifice to house fire-fighting equipment to be used some time, somewhere, for some fire;

If you are interested in participating in the actual solution of the difficult problem of the distribution of medical care; interested in avoiding political medicine and preserving the private practice of medicine in the United States—

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The Functions of the National Physicians' Committee
The functions of the National Physicians' Committee are largely technical. The objectives are clearly defined.

- In the public interest to preserve, in the United States, our system of private medical practice;
- Familiarizing the public with the facts in connection with the values, the methods and the achievements of American Medicine;
- To aid in the development of plans and to encourage the utilization of facilities that will result in the most widespread distribution of the most effective medical care and surgery.

The House of Delegates of the American Medical Association is the legislating, policy-forming body of the medical profession.

The National Physicians' Committee is an independent

organization of physicians. Its planning and operations are performed within the framework of the policy findings and the decisions of the AMA House of Delegates.

PATHOLOGISTS HOLD MEETING

At the first Annual Meeting of the Oklahoma Association of Pathologists held in Tulsa in May, Dr. Howard C. Hopps was re-elected president, Dr. Lee Lowbeer was elected vice-president, Dr. Bela Halpert, secretary-treasurer, and Dr. Hugh G. Jeter, member of the council.

Meetings of the Association have been held monthly since the organization of the Association in December, 1944. At the meeting held on July 8, Dr. Howard C. Hopps presented a paper, "Periarteritis Nodosa, An Experimental Study."

DR. TOM LOWRY GIVES FACTS ABOUT MEDICAL SCHOOL

Oklahoma City Times, July 11, 1945. A few days ago it was our privilege to hear Dr. Tom Lowry, head of the O. U. School of Medicine, give some interesting facts about the medical school, hospitals, public health work, preventable diseases, etc. People pay little attention to doctors and medical stuff until they get sick, but it would do well for folks in Oklahoma to give heed to the observations of this good doctor who is spokesman for a great work of improvement that is going on in the state, seeking to keep people from getting sick and getting them well quicker when they do. So in this column we are passing along some of the more pertinent points of his talk.

Dr. Lowry, after 25 years at bedsides and 15 years in the same office, was retired two years ago by a slightly damaged heart, but that heart was warm. Perhaps he should have spent the rest of his life fishing in Grand Lake, Texoma or the Illinois river but, instead, he chose another hobby, one close to him, that of helping to guide the medical school and its hospitals.

There are 286 students in the School of Medicine; 168 of these are in the army, 74 in the Navy, and 44 on civilian status; they are from 57 counties in the state. The next semester, opening soon, will admit 75 new students, choosing the best from among more than 150 who have applied for admission.

There have been 1,300 graduates since the school started; 524 of these are practicing in 124 towns in 65 counties in Oklahoma; 600 of the graduates are in the armed forces, and 26 of them have been decorated.

Doctors who have graduated from the Oklahoma School compare most favorably with graduates of schools elsewhere. Confidential questionnaires recently were sent to administrators of hospitals where 47 graduates served internship. In the returns 35 of the young Oklahomans were rated above the average, nine of them average, and only two below average.

There are 470 beds in University hospital and the Crippled Children's hospital; these hospitals are vital working arms of the medical school. There are 30 full-time teachers in the school and in the hospitals and, at present, part-time clinical teachers, doctors who live in the city; these part-time teachers draw about \$30 a year each, hardly enough to pay car fare.

The army's evacuation hospital No. 21 is sponsored by the Oklahoma medical school which has supplied 37 doctors. This hospital was activated in California in June, 1942, was moved to Guadalcanal in October, 1943 and to Bougainville in February, 1944, then landed on Luzon

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shortly after D-day. How these Oklahoma doctors worked to save lives of the wounded, and reduce the toll of disease among men, would be worth several columns.

But let's get back home. There are 1,000 patients in this state, ill with tuberculosis or cancer or any one of many curable diseases, on the waiting list to get into hospitals. Twenty counties, of the 77, in the state have no hospital beds. The state as a whole has 1.7 hospital beds per 1,000 population; the U. S. average is 3.5. Oklahoma City alone is short hundreds of hospital beds to meet the requirements.

The last session of the legislature enacted 10 new laws to provide some facilities and raise the level of health work and treatment of disease. The state ranks well in taking care of crippled children, but too many grownups are left to root hog or die; the new health program, just being formed, will serve to improve that condition.

The medical school is setting up schools of public health, physician medicine and public health nursing to work with existing schools for dietitians and technicians. Students of medicine will be trained to be teachers of health.

The main need: More hospitals and more doctors. The hospital should be provided and the doctor will have to be schooled and trained. Authorities expect only about two-thirds of the doctors in the armed forces to return to civilian practice.

Legal Opinions

STATE OF OKLAHOMA
OFFICE OF THE ATTORNEY GENERAL
Oklahoma City

June 27, 1945

Jas. D. Osborn, M.D.
Secretary, Board of Examiners
in the Basic Sciences
Frederick, Oklahoma
Dear Sir:

The Attorney General acknowledges receipt of your letter dated June 24, 1945, wherein you in effect ask if "The Oklahoma Association and College of Naturopathy Doctors, Inc.," which was chartered as an educational association in this state on June 3, 1939, has authority to issue the degree of "Doctor of Naturopathy and Physiotherapy," and if a person holding such a degree from said college has the right to practice naturopathy and/or physiotherapy for compensation in this state.

In reply you are advised that in an opinion dated November 28, 1939, addressed to the Honorable C. C. Childers, Secretary of State, the Attorney General in effect held that the institution above named did not have authority to issue degrees such as are mentioned by you, and that persons holding such degrees did not have the right to practice naturopathy or physiotherapy for compensation under authority thereof. A copy of said opinion is enclosed herewith for your information.

Yours very truly
RANDELL S. COBB

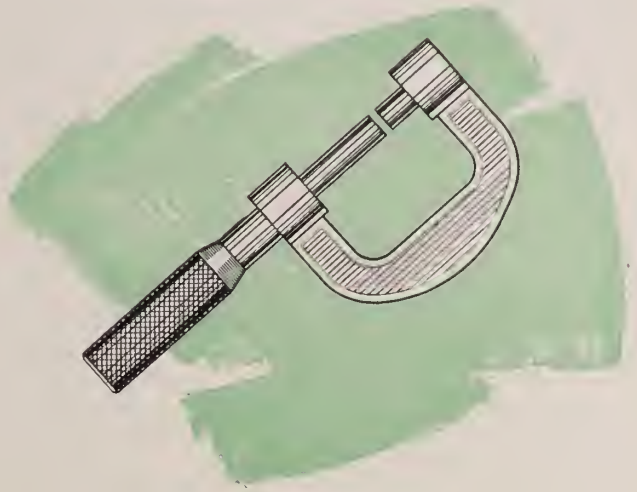
Attorney General of Oklahoma
By Fred Hansen
First Assistant Attorney General

FH:LW
Enc-opinion
Approved in Conference
June 27, 1945
True Copy July 2, 1945.

November 28, 1939

Honorable C. C. Childers,
Secretary of State
Building
Dear Sir:

The Attorney General acknowledges receipt of your



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letter dated November 27th, 1939, wherein you state that "The Oklahoma Association and College of Naturopath Doctors, Inc.," same being incorporated under the laws of this State as an educational association, recently submitted to you a list of the names of persons to whom it had issued diplomas since the date of its incorporation and asked you, as Secretary of State, to file said list in your office under the provisions of Section 11, Article 28, Chapter 24, Oklahoma Session Laws 1937 (Basic Science Act), which in part provides:

"Each board now existing or hereafter created for the purpose of licensing persons to practice any of the healing arts within the State of Oklahoma, shall be required to file with the Secretary of State the names of all persons receiving licenses from said Board since the date of its creation***"

You further state that, acting under the oral, unofficial opinion of one of the Assistants in this office, you have so far declined to file said list, but that you desire official, written opinion of the Attorney General in the premises.

In reply, you are advised that the purpose for which said corporation is formed is set forth in the amended Articles of Incorporation thereof, as follows:

"That the purposes for which this corporation is formed is to fundamentally seek, teach and embody the truth, principally to study nature, mind and man, and ultimately to enable the human being to bring within right the highest possible attainments consistent with his in-born qualities, tendencies and desires, to interpret nature, to unfold humanity and to teach, disseminate and develop the arts and sciences of naturopathy and physiotherapy, (the names of which are synonymous and the materia medica of same being identical), 'in their theoretical, practical modes of restoring and maintaining health,' and incident thereto, to raise the standard of qualification, to increase the proficiency of its members, to promote the science of uaturopathic and physiotherapeutic therapeutics and for the interchange and discussion of matters of mutual interest, and to give the members legal protection. The materia medica shall consist of light, air, water, color, heat, electricity, exercise, suggestion, rest, diet, massage, magnetism, physical and mental culture. The professional terms of the above being commonly known as electrotherapy, thermotherapy, phototherapy, chromotherapy, vibrotherapy, thalamotherapy, hydrotherapy, mechanotherapy, corrective arthopedic gymnastics, neurotherapy, psychotherapy, mineral baths, and dietetics which shall include the use of foods of such biochemical tissue-building products and cell salts as are found in the normal body; and the use of vegetable oils and dehydrated and pulverized fruits and vegetables uncompounded and in their natural state.

"To appoint and designate a board of examiners who shall examine all applicants and applications for membership in the association. All members who shall have passed a satisfactory examination before the board shall be issued a diploma, conferring the degree of doctor of naturopathy and physiotherapy upon them; such diploma shall be signed by the members of the board of examiners and the president and the secretary of the association."

In consideration of Section 11, supra, the above quoted corporate purposes of the Oklahoma Association and College of Naturopath Doctors, Inc., and the fact that said corporation has asked you to file the list above mentioned in your office, it is clear that said corporation takes the position that the board of examiners referred to in said Articles of Incorporation is a board "created for the purpose of licensing persons to practice" one of the branches of the healing art in this

State within the meaning of Section 11, supra, and that persons receiving diplomas from said board are "persons receiving licenses" within the meaning of said section. However, from an examination of said Section 11 and the Basic Science Act as a whole, the Attorney General is of the opinion that said Section 11 only requires or permits the boards of examiners of branches of the healing art created and existing under the laws of this State, to wit: medicine and surgery, osteopathy and chiropractic, to file lists such as are above mentioned, and that the persons named in said lists must be persons who have been licensed by said boards of examiners to practice medicine and surgery, osteopathy or chiropractic. In this connection, it should be noted that under the provisions of Section 4634 and 4635, Oklahoma Statutes 1931, if a person not practicing within the statutory scope of his profession under a license issued to him under the laws of this State by the Board of Medical Examiners, of Osteopathy, of Chiropractic, or of Chiro-pody,

"shall append to his name the letters 'M.D.,' 'Doctor,' 'Professor,' 'Specialist,' 'Physician,' or any other title, letters or designation which represent that such person is a physician, or who shall for a fee or compensation treat disease, injury or deformity of persons by any drugs, surgery, manual or mechanical treatment whatsoever,"

said person

"shall be guilty of a misdemeanor, and shall, upon conviction thereof, in any court having jurisdiction, be fined for the first offense in any sum not less than One Hundred (\$100.00) Dollars, and not more than Five Hundred (\$500.00) Dollars."

The Attorney General is of the further opinion that the treatment of disease, injury or deformity of persons for a fee or compensation by massage, muscular or osseous adjusting or manipulation, or by the use of such mechanical devices as may be used in what is commonly

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called the practice of electrotherapy, thermotherapy, phototherapy, chromotherapy, vibrotherapy, thalamotherapy, hydrotherapy, mechanotherapy, nenrotherapy, and psychotherapy, is the treatment of disease, injury or deformity of persons by "mannal or mechanical treatment," within the meaning of the above quoted statutory provisions, and that if a person not practicing within the statutory scope of his profession under a license issued to him under the laws of this State by the Board of Medical Examiners, of Osteopathy, of Chiropractic or of Chiropody, shall treat disease, injury or deformity of persons for a fee or compensation by massage, muscular or osseous adjusting or manipulation, or by the use of mechanical devices such as are above mentioned, said person is subject to the penalty set forth in Sections 4634 and 4635, supra.

The Attornel General is, therefore, of the opinion that you should not, as Secretary of State, file the list above referred to in your letter under the provisions of Section 11, Article 28, Chapter 24, Oklahoma Session Laws 1937.

The opinion above expressed is supported by an opinion of the Attorney General dated July 1, 1926, addressed to the Honorable L. B. Yates, County Attorney of Jackson County, Altus, Oklahoma, an opinion of the Attorney General dated Augnst 18, 1938, addressed to Dr. J. D. Osborn, Jr., Secretary, State Board of Medical Examiners, Frederiek, Oklahoma, an opinion of the Attorney General dated June 13, 1939, addressed to Honorable Victor Eckler, County Attorney of Jefferson County, Wanrika, Oklahoma, and an opinion of the Attorney General dated August 3, 1939, addressed to the Honorable Judson H. Pierce, Connty Attorney, Noble Connty, Perry, Oklahoma.

We are mailing copies of this opinion to W. A. Neville, 907 A. North Hudson, Samuel Phillips Morrall, 204 Northeast 13th, and Christena E. Boley, 912 Northwest 5th, all of Oklahoma City, Oklahoma, same being the officers and directors of the Oklahoma Association and College of Naturopath Doctors, Inc., for their information.

Yours very truly,

FOR THE ATTORNEY GENERAL

Fred Hansen,

Assistant Attorney General.

FH:BM

(Copied and proof-read by BM)

(Copied 3-8-45 by FM)

Approved in Conference

November 29, 1939.

True Copy July 1, 1945.

Obituaries

Arthur W. White, M.D.
1877-1945

Dr. Arthur W. White, Oklahoma City, died on June 11 from a heart ailment. With his passing the profession has suffered the loss of an understanding, cooperative associate and a skilled scientific teacher. The members of his County Society have expressed their feelings as to the loss of their fellow physician and friend.

Dr. White was born on June 3, 1877 in Paxton,

Ill. He graduated from Rnsh Medical College in 1902, having received his B. L. Degree from Monmouth in 1898. Dr. White was attending physician at St. Anthony Hospital from 1906 to 1918 and consulting physician since 1918. He was a Professor of Pathology at Epworth Medical School from 1905 to 1907 and Professor of Clinical Medicine from 1907 to 1911. For several years, Dr. White served as Professor of Clinical Medicine at the University of Oklahoma School of Medicine and was Chief of Medical Service at the University Hospital, retiring in 1943. From that time he was Professor Emeritus.

In World War No. I, Dr. White served as a Captain in the Medical Corps from 1918 to 1919 and was retired as Major.

He was a member of the Oklahoma County Medical Society, the Oklahoma State Medical Association, the American Medical Association, was a charter member of the Oklahoma City Academy of Medicine, a member of the Internists Association and a Fellow of the American College of Pathology.

G. C. Croston, M.D.
1877-1945

Dr. G. C. Croston, Sapulpa, died at his home on May 30 of a heart ailment from which he had suffered for the last two years.

Dr. Croston was born in Bolton, England in 1877 and came to Iowa in 1879 with his parents, Dr. and Mrs. Thomas Croston. He was gradnated from Northwestern university in 1905 and came to Sapulpa from Lucas, Iowa, in June, 1907.

He was a member of the Oklahoma State Medical Association, the American Medical Association, past president of the Creek County Medical Society and a member of the Presbyterian church. He has been active in many Sapulpa civic clubs and fraternal organizations, was a pioneer member of the Rotary club, but resigned from all such affiliations during the past two years, because of poor health.

Surviving are the widow and five sons, Merwyn, of Tulsa; Harry, Sapulpa; Major George of Romulus Field, Michigan; Millard of Kaw City and Jerome of Sapulpa.

E. N. Lipe, M.D.
1878-1945

Dr. E. N. Lipe, Fairfax, died at his home on June 7. He graduated from Memorial Hospital Medical College of Chicago in 1902 and has been a physician in Fairfax for twenty-three years. The following is taken from the Fairfax "Chief", of June 7.

"Dr. Lipe was a staunch npholder of the high ideals of the profession through a period that has brought great advances in medicine and snrgery. It is now up to a younger generation of the profession to carry on from where the old-timers leave off, and they are highly capable of doing it."

W. H. Powell, M.D.
1872-1945

Dr. W. H. Powell, pioneer Murray county physician, died June 7 in Sulphur after several weeks' illness.

A native of Mississippi, Dr. Powell was graduated from Baylor university medical school and settled in what is now Murray County in 1894. He had practiced



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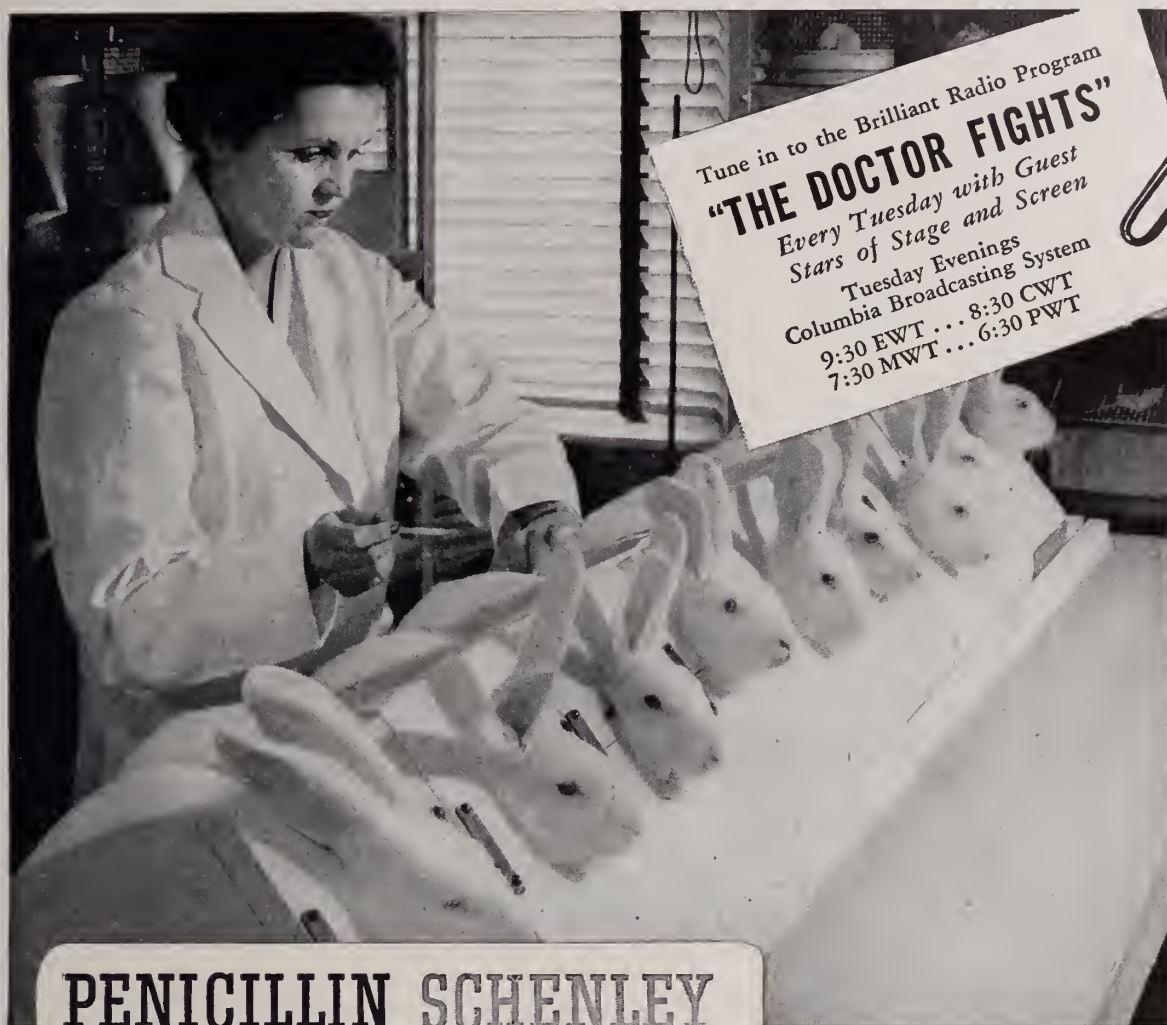
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medicine there ever since, serving for a number of years as city physician of Sulphur.

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THAT—All amounts paid to the plan in excess of reasonable reserves for epidemics and operating requirements are used to give more benefits to members. There have been twelve new benefits added since the plan started in 1940.

THAT—The services offered by the plan are guaranteed by 91 hospitals in Oklahoma.

THAT—If he leaves his place of employment, he may continue the service by paying direct on a quarterly, semi-monthly or annual basis.

THAT—*He may choose his own doctor.*

THAT—*He may choose his own hospital.*

THAT—Upon admission at the hospital, he presents his identification card—no cash is needed. The Plan pays the hospital direct.

THAT—Farmers are now eligible for Blue Cross membership through Farm Bureau, Home Demonstration Clubs and Farm Security Administration. More than 30,000 of our present members are farmers.

THAT—Penicillin, the new wonder drug, has just been added to the list of drugs provided as Regular Service Benefits for members of the Oklahoma Blue Cross Plan.

Book Reviews

AMERICAN MEDICAL PRACTICE. Bernhard J. Stern, Ph. D. The Commonwealth Fund, New York. 156 pages. 1945.

We learn from the foreword of this intriguing little book that "The Committee on Medicine and the Changing Order was established by the Council of the New York Academy of Medicine in the winter of 1942 and began its work in February, 1943. This action was taken in the conviction that the medical profession is confronted by problems which require thorough study, and that the Academy had both the opportunity and the responsibility to contribute to the effective solution of these problems."

The ambitious objectives are listed as follows:

"To explore the possibilities and to formulate methods of maintaining and improving standards of quality in medical service, including medical research, medical education, the maintenance of health, both physical and mental, the prevention of disease.

"To study the means of making available to larger groups of people and to the country as a whole the best known practice in preventive and curative medicine.

"To explore the possibilities and to formulate proposals of distributing these services not only to a larger number but also at a lower per capita cost than the present system permits."

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The Preface by Iago Galdston, M.D., briefly surveys the content of the text and seems well satisfied with the results achieved through the author's difficult excursion in this difficult field. The magnitude of the task may be partially conceived by a listing of the chapter headings: Social and Economic Changes in American Life; The Expanding Horizons of Medicine; The Specialist and the General Practitioner; The Supply and Distribution of Physicians; The Patient Load in Medical Practice; The Income of Physicians; The Distribution of Medical Services; Appendix, the Effect of Recruitment on the Supply of Physicians in Civilian Areas.

While the author deals with many of the facts having to do with the history of medicine in an interesting and persuasive fashion and while in succeeding chapters he presents social, economic and racial factors in logical sequence with the support of many figures from varied sources, the reviewer feels that his implications and inferences are too limited in their application. While the need of more adequate medical care for those on relief and in the low income groups is readily admitted, it should be remembered that these groups are equally in need of more adequate food and fuel, better clothing, better housing, transportation and sanitation and that medicine cannot take the place of fundamental health sustaining factors. These needs are casually mentioned but not sufficiently stressed. Giving income to the indigent and low income groups might be better than medicine. Prevention is always better than cure.

The little volume contains much valuable information and the author's method of presentation offers much food for thought—serious thought.—Lewis J. Moorman, M.D.

BELOVED CRUSADER. Lawrence F. Flick, M.D., by Ella Marie Flick. Dorrance and Company, Philadelphia. 1944. 390 pages. Price \$3.50.

In this thrilling, instructive, historical volume, dealing with the life of Dr. Lawrence F. Flick, we find a daughter's loving tribute to a distinguished father. Even though this is a work of love, it represents a faithful record of facts. Peculiarities in personality and unfortunate traits of character are frankly admitted. Even though progress occasionally was hampered by these adverse characteristics, their presence renders the story of his life more human and more interesting. In the book of his life the debits are dwarfed by the huge sum of accrued credits.

Stimulated by his own personal experience with tuberculosis he set about the task of providing knowledge and help for other potential or actual sufferers from the disease. His activities in this field are partially expressed in the following list quoted from a review by Robert G. Patterson, Penn Magazine of History and Biography, January, 1945.

"His rare ability to organize against the disease is revealed in an extensive list of organizations and institutions in which he was active, among them Rush Hospital for Consumptives and Allied Diseases, 1890; the Pennsylvania Society for the prevention of Tuberculosis, 1892; Society for the Care of Poor Consumptives and White Haven Sanatorium Association, 1895; White Haven Sanatorium, 1901; Henry Phipps Institute for the Study, Treatment and Prevention of Tuberculosis, 1902; The National Tuberculosis Association, 1904; and the Sixth International Congress on Tuberculosis, Washington, D. C. 1908. In addition, Dr. Flick was the author of three books on tuberculosis."

His monumental work, Development of Our Knowledge of Tuberculosis, contains approximately 800 pages. His daughter lists The Henry Phipps Institute and The White Haven Sanatorium as the great achievement in his life. With these should be included the organization of the first group in the United States, professional and lay, for the control of tuberculosis; The Penn Society for the Prevention of Tuberculosis, April 22, 1892. The history of the Henry Phipps Institute alone should command the attention of doctors throughout the world.—Lewis J. Moorman, M.D.



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★ FIGHTIN' TALK ★

From Brunswick, Germany, comes the following from MAJOR EARL E. BIGLER, Claremore: "I thought maybe some of them from Rogers County might be curious as to whether I was dead or alive.

"A few of the facts are that I have been overseas eighteen months; my unit was under COLONEL WILHITE in England for a couple of weeks at one time; I saw MAJOR HAMM of Oklahoma City in Paris the first week in April; I have seen a good deal of England, France, Belgium, Holland and have been living in Germany since the day after Christmas. That all adds up to four campaign stars and a lot of jeep riding. It looks as though I may be here some time yet although anxious to get home to see my daughter who was born while I was in New York waiting for my boat ride.

"One other thought occurs to me. You can well believe any atrocity pictures you see of those concentration camps. They are not isolated cases nor exaggerated for effect, and fuller appreciation of conditions by the home folks would result if they could only pipe the smell into the movie houses."

Upon looking over a copy of "Hospital Hi-Lites" of the United States Naval Hospital, Aiea Heights, T. H., we came across the following article:

"Here at Aiea the ancient axiom has entered the field of modern medicine, into one of the newest divisions of medical science—Allergy.

"When confronted with several new types of allergy, over a year ago, DR. BLUE (LT. COMDR. JOHN BLUE, Guymon), head of the hospital's allergy department, set about creating another child of Mother Necessity. Pollens they are called. Now pollens were nothing new to Dr. Blue, but pollens of the grasses, flowers, trees, dust, etc., which were causing hundreds of service personnel serious trouble creating such diseases as asthma were not only new but almost entirely unknown. Manufacturing druggists did not make pollen extracts which were taken from trees, flowers, etc., which are native only to the Hawaiian islands, so Dr. Blue and his band of corpsmen set about to gather up hundreds of specimens of local flowers and plants and made their own pollen extract. Their quest took them to every part of the Island of Oahu. Over hill and dale they traveled, along beaches and high on the mountain slopes.

"The results of their efforts is the modern Allergy Clinic which has been established on Ward 23, one of the first of its kind ever operated in the islands. Here research is carried out in the broad field of allergy and patients are subjected to numerous tests until the cause of their trouble is proven.

"Most of the cases treated in the allergy clinic are diseases of the upper respiratory system, but skin diseases are sometimes diagnosed by the use of pollen extracts.

"The Allergy Department's quest for pollens has

taken them far beyond the field of plants (plant life was their first concern). They have collected such things as common house dust, dust from Aiea's red clay, mattress and bedding dust, sand, coral and cosmetics.

"After these pollens were tracked down and found they were collected and extracts made. These extracts are used primarily to make skin tests to determine what causes the symptoms. The extract is also injected into the patient's body to increase his resistance to the plant pollens.

"Kalu brush, algeroba tree, haole koa and many other such names might sound like pidgin English to the average layman, but to an allergy specialist like Dr. Blue, who has devoted much time to a study of Island plants, they spell trouble for American Servicemen serving in the Pacific Ocean area. The Navy tries to keep men with major allergies out of the service, but where as nearly fifty per cent of all Americans are allergic to something the task of the specialist becomes rather gigantic. Of course Aiea's Allergy Clinic is not all pollens, extracts, and mountain climbing. A scientific approach to each individual problem is made by Dr. Blue and his well-trained staff of nurses and corpsmen. A complete history of each patient's trouble is written and analyzed, the type of things which give him some relief or under what conditions he receives relief are studied. In many cases he is placed on a diet. Skin tests are made with the many extracts, always kept on hand at the clinic.

Hundreds of out-patients are treated every month as well as patients from other wards of the hospital which added up makes the allergy clinic a pretty busy place for the staff."

COLONEL F. REDDING HOOD, Oklahoma City, is back with us again and has been discharged from the Army. He reopened his office on July 1. Colonel Hood was commissioned in the Army Medical Corps in 1942 and was sent to La Guardia General Hospital in New Orleans.

Dr. Hood is very glad to again be back in practice and says that he has found things in general just the same—the practice of medicine hasn't changed. This, we think, sounds good and everything possible will be done to keep it that way for you when you return.

We were glad to receive a letter recently from LT. TURNER BYNUM, Chickasha, who is now on Okinawa. In part, his letter reads: "Have been here since the beginning of this campaign having worked with an Army Field Hospital for the first month. Just today received a commendation for the work done there. I still think the Navy has the best medical department and the Marines the most rugged fighters.

"Will certainly be glad to get back to Oklahoma and a little quiet medical practice and I am certain that I will be pleased with the medical set up there

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Captain T. J. Huff Liberated

CAPTAIN T. J. HUFF, Walters, was freed April 29 from a German Prison Camp. "I wasn't a victim of physical violence—the only objection I had to being a German prisoner was that they starved us, froze us and marched us," said Captain Huff.

Captain Huff is a graduate of the University of Oklahoma medical school in 1942, was a physician with an artillery battalion, but was never with a particular division all the time. The following statement from Captain Huff was published in the Daily Oklahoman of July 8.

"On one particular day—I remember distinctly—it was Sunday, last January 14, we were in Limburg getting ready to leave. We were loaded on boxcars, but hours afterwards we were still sitting there. Then American planes came and worked us over.

"We had a few casualties, one of which was in the same car I was in. He had a compound fracture of the hip and an arm was almost completely severed. Since I was the only doctor in that particular car, I completed the amputation and we took the fellow back to the hospital which was a short way off. He died later in the hospital here, I understand.

"Whenever we got strafed and bombed—it happened on three occasions—we always had several casualties."

LT. G. H. GUILD, JR., Shidler, has been called to active duty, reporting July 1. He graduated from the University of Oklahoma Medical School in September, 1944.

MAJOR V. M. RUTHERFORD, Woodward, has re-

cently been promoted from Captain. He is now stationed in a hospital near Manila. Before going to the Philippines, during the Luzon campaign, Major Rutherford was stationed on New Guinea.

Medical School Notes

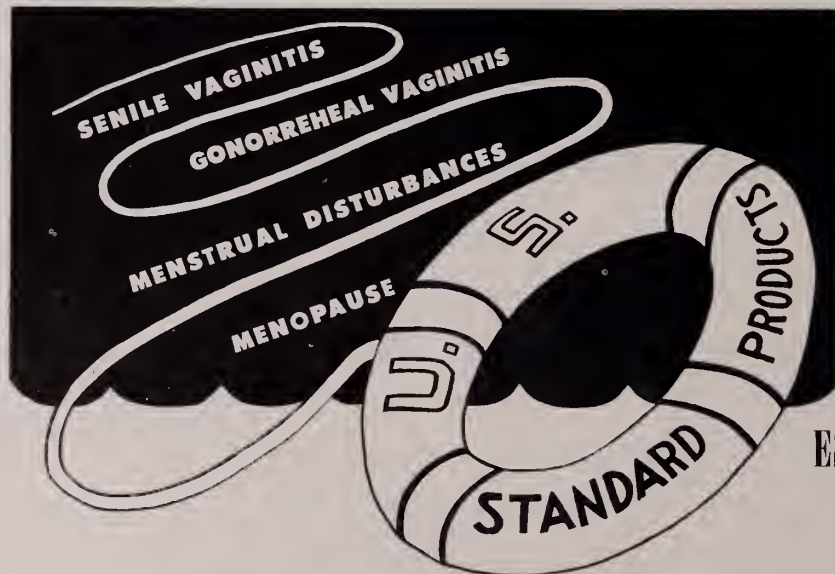
The Postwar Medical Education Committee of the School of Medicine was appointed several months ago for the purpose of making a preliminary study and outlining a tentative schedule for postgraduate courses to be offered the doctors returning from government service.

The study was inaugurated by sending two questionnaires to all the alumni of the school in active service at that time, to determine their reactions to such a course and to ascertain any special interests which they might have. With this information, several meetings were held and all phases of the work discussed informally. The following plan has been devised: The courses to be offered by the School of Medicine have been divided into three groups—(1) informal course, (2) residencies, and (3) formal course.

In the near future, a bulletin of information on this postgraduate work will be published and will be mailed to doctors in the service.

Dr. John Powers Wolff, who was granted a leave of absence to serve with the Army on July 3, 1942, resumed his teaching duties in the School of Medicine on July 1, 1945.

Class work for the first semester of the 1945-46 school year began at the School of Medicine on July 2 with the enrollment of 70 freshmen students. There are a



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total of 280 students, 129 of these are A.S.T.P. trainees, 80 are enrolled under the Navy V-12 Program, and there are 71 civilians. Twenty-four of these civilians are women, and sixteen of these are members of the freshman class. Forty-five non-residents are in attendance at the School of Medicine.

The Oklahoma Association of Pathologists met at the Medical School on July 8 and dinner was served at the University Hospital. Dr. Howard C. Hopps, Professor of Pathology, gave a talk on "Periarthritis Nodosa, An Experimental Study."

Captain John D. Ashley, who served as an intern and a resident in medicine at University Hospitals from July, 1940 to July, 1944, was a recent visitor at the Hospitals. He spoke to the interns about his experiences during the last year in Germany.

New interns who began service on July 1, at the University Hospital, and the medical college from which they graduated, are listed below:

Dr. Richard H. Burgtorf, The University of Oklahoma.
Dr. Marvin Allen Childress, The University of Oklahoma.

Dr. Bedford King Duff, The University of Texas.

Dr. Marvin Bryant Hays, The University of Oklahoma.

Dr. James Arthur Kennedy, The University of Wisconsin.

Dr. William Penn Lerblance, The University of Oklahoma.

Dr. Albert Ziegler McPherson, Duke University.

Dr. William R. Paschal, The University of Oklahoma.

Dr. Charles G. Shellenberger, The University of Oklahoma.

Dr. Lorn M. Shields, The University of Colorado.

Dr. Walter Fred Speakman, The University of Oklahoma.

Dr. Byron Fremont Smith, The University of Oklahoma.

Dr. Gerald M. Steelman, The University of Oklahoma.

Dr. James Harold Tisdal, The University of Oklahoma.

Dr. Howard Grafflin Tozer, The University of Oklahoma.

Dr. Cecil Ray Waterbury, The University of Oklahoma.

Residents appointed to serve from July 1, 1945, to March 31, 1946, the schools from which they graduated and the hospitals where they served their internships are listed below:

Dr. John Hatchett Clymer, The University of Oklahoma, Jr. Resident in Surgery. (The University Hospitals.)

Dr. H. Phillip Dohn, Marquette Medical School, Sr. Resident in Orthopedic Surgery, (Army.)

Dr. Safety R. First, The University of Oklahoma, Sr. Resident in Medicine. (Hillcrest Memorial Hospital, Tulsa.)

Dr. Herman F. Flanigin, The University of Oklahoma, Sr. Resident in Surgery. (The University Hospitals.)

Dr. Robert Jesse Morgan, The University of Oklahoma, Jr. Resident in Medicine, (St. Paul's Hospital, Dallas, Texas.)

Dr. Dwight L. Sabroske, Ohio State University Dental College, Resident in Dentistry.

Dr. Frances R. Sherman, Rush Medical College, Resident in EENT, (Charity Hospital, New Orleans, Louisiana.)

Dr. Adolph N. Vammen, The University of Oklahoma, Jr. Resident in Obstetrics and Gynecology, (The University Hospitals.)

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MEDICAL ABSTRACTS

PENICILLIN IN MASTOIDITIS AND ITS COMPLICATIONS. F. J. Putney, M.D. Archives of Otolaryngology. Chicago, volume 41, page 247-251, April 1945.

Florey in 1943 reported on the clinical use of penicillin in the treatment of diseases of the ear. The author has used penicillin clinically since 1943, and in his paper he reports on his experience gained from this treatment of various otological diseases.

His series includes 10 cases of mastoiditis and its complications, in which the organisms, either streptococci or staphylococci, were found to be sensitive to penicillin, and their growth was inhibited by 0.1 unit or less of penicillin per cubic centimeter on culture. Failure of organisms to respond to penicillin is usually due to a resistant bacterial strain. When, after 3-4 days of therapy with penicillin, there has been no improvement in the appearance of wound and the purulent drainage continues, one should suspect that the organism is resistant to the drug, and tests for sensitivity should be made.

Adequate surgical intervention, in addition to treatment with penicillin, was necessary to effect a cure in the majority of the author's patients. But, a decided decrease in pain, with a general feeling of well-being, is usually noted within the first 48 hours of treatment.

Originally, the author administered the penicillin intravenously, either by repeated venous punctures every two hours, or by continuous drip. Both methods have largely been supplanted by the intramuscular route. Yet, continuous drip administration may still be preferable for extremely ill patients with grave infections when a high, prolonged blood concentration of penicillin is desired.

Penicillin used locally is also bacteriostatic. In general the dose employed was 25,000 units intramuscularly every three hours, which was reduced to 15,000 units as the patient improved, the three hour interval being maintained. No toxic reactions to the drug were encountered in his series of cases.

In the postoperative care penicillin was used locally by various methods: (1) Irrigation through a rubber Dakin tube after primary closure of a wound. (2) Irrigation to the open mastoid cavity, and (3) Packing the open wound with gauze impregnated with penicillin at the daily dressings. In the complicated cases the wound was left open and a secondary closure was performed from seven to ten days later; The author, however believes that these wounds can be closed primarily with little hazard, provided the patient is receiving penicillin systematically and local application is continued.

After simple mastoidectomies and closure of the wounds, local penicillin irrigation was employed without intramuscular use, and, even by this method, prompt healing occurred. If penicillin is used locally, it is not

necessary first to remove the secretion from the mastoid wound. It makes also little difference whether the drainage tube is placed at the superior or inferior end of the wound. The strength of the solution used locally was 250 units per cubic centimeter. The healing of indolent wounds that continue to drain after mastoidectomies may be hastened by the local application of penicillin.

The author had six patients with thrombosis of the lateral sinus who have been treated with penicillin. The drug was given both postoperatively and preoperatively. By either method, the results appeared equally satisfactory, and no appreciable difference was noted. By the preoperative use of the drug, control of the acute phase of infection can be obtained before the operation; hence, this method of use seems to be a better one. In any event, the thrombus should be removed by operation, though in three cases this was not done, and yet, the patients recovered. The author's impression is that penicillin, by combating the formation of septic thrombus, is of definite value and is an added precaution in preventing the spread of the disease. The rapid response of the infection to penicillin is seen in the prompt decline of temperature, disappearance of headache, general feeling of improvement and sterilization of the blood stream. Routine dosage of 25,000 units of penicillin intramuscularly every three hours reduced to 15,000 units as improvement resulted was generally practiced. One should keep in mind, however, that penicillin alone is not sufficient to cure or prevent thrombosis, and that surgical intervention is an equally important factor in obtaining permanent healing.

In a case of mastoiditis, there was improvement with the use of penicillin without cure, until mastoidectomy was performed. Healing was obtained in a patient with petrositis and serious meningitis through treatment with penicillin plus a simple mastoidectomy. In a case complicated by cerebellar abscess, the mastoid infection was controlled by the use of penicillin, but the signs of cerebellar irritation continued even though the temperature returned to normal. At operation the pus in the brain abscess was found to be sterile, thus demonstrating the efficiency of the drug in eliminating bacteria.

Penicillin does not readily infiltrate into the cerebrospinal fluid, but it can be used with safety to produce good therapeutic effect in case of meningitis when it is directly injected into the spinal canal. If there are bacteria in the cerebrospinal fluid, such an intrathecal therapy is definitely indicated. But, physical signs of meningeal irritation and spinal fluid findings of increased pressure and of leukocytes do not themselves constitute sufficient reason in the author's opinion for using intrathecal injections of penicillin.—*M.D.H., M.D.*

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USE OF SKELETAL TRACTION IN THE HAND. Milton C. Cobey, Harvey C. Hansen, and Marion H. Morris. *Southern Medical Jr. XXXVII, 309, 1944.*

Skeletal traction is often more efficient than skin traction, and it is more comfortable. Considerably more pull can be obtained, and reduction is more accurate. A simple and convenient type of skeletal traction is the ordinary surgical towel clip. Routine aseptic surgical technique is followed, with draping of the parts. A small skin incision is made, and the traction device is placed in the proximal end of the incision to prevent skin tension. Sterile dressings are used about the clip, and are not to be disturbed until the fracture has united. Some type of fixation, corks or adhesive, may be employed to prevent to-and-fro excursions of the clip. Pull is exerted in the longitudinal axis of the bone. The clip is inserted under local or general anesthesia, the fracture is reduced, and traction is applied. This device is useful in fracture or dislocation of the thumb and of the metacarpals. After the clip has been inserted and dressed, a plaster cast with a banjo splint for traction is applied. The clip is not used for fractures of the phalanges. The use of skeletal traction in fifty-nine cases is reported. —*E.D.M., M.D.*

PAIN AND DISABILITY OF SHOULDER AND ARM DUE TO HERNIATION OF THE NUCLEUS PULPOSUS OF CERVICAL INTERVERTEBRAL DISKS. Jost J. Michelsen and William J. Mixer. *The New England Journal of Medicine, CCXXXI, 279, 1944.*

Cord compression was formerly considered a diagnostic criterion on herniation of the cervical discs; it now seems likely that this feature was overemphasized. Root symptoms may just as well occur here as in the lumbar area. Michelsen and Mixer found cord compression in six cases, while nerve-root involvement occurred in eight cases.

Eight cases which are operated upon, are reported in detail. It is indicated that pain and disability of the shoulder and arm were prominent symptoms. There were lesions at the fifth interspace in four cases, at the sixth in three, and at the seventh in one. The clinical data were brought together in a syndrome that comprised root pain and local sensory and motor disturbances, as well as positive roentgenographic and cerebrospinal fluid findings. The distribution of the sensory abnormalities was compared with standard dermatome charts. Emphasis is given to the importance of a systemic neurological examination in cases of pain and disability of the shoulder and arm. The removal of the disc fragments by laminectomy or subtotal hemilaminectomy gave good results. The addition of this new entity to the long list of disorders which give rise to arm and shoulder signs and symptoms ought to be a great help in the clarification of these perplexing problems.—*E.D.M., M.D.*

LYMPHOID HYPERPLASIA OF THE NASOPHARYNX: A STUDY OF ONE HUNDRED AND THIRTY-ONE AUTOPSY SPECIMENS. Hollender, A. R., and Szanto, P. B. *Archives of Otolaryngology, volume 41, pages 291-294, April 1945.*

According to the so-called cranio-caudal concept of the development of Waldeyer's ring the developmental and involutional changes of the lymphatic apparatus of the pharynx occur in the same sequence. The development begins after birth and attains its peak between the second and third years of life. At puberty the involution of these structures generally approaches completion. The development of the palatine tonsils may begin early in infancy but usually later than that of the nasopharyngeal and tubal tonsils. The involution of palatine tonsils is observed in the majority of persons after the fourth decade of life. The lingual tonsils comprise the final link in the Waldeyer ring, and exhibit the maximum development in adults at about this same period.

In elderly persons the lingual tonsils are usually well preserved.

Hyperplasia of the nasopharyngeal tonsil in adults is not always associated with clinical symptoms. The production of symptoms is influenced by infection, and by the size of the nasopharyngeal vault. The latter, according to the authors, is the more important factor. If the vault is large, so that no pressure results from the hyperplasia of the contained lymphatic tissues, symptoms of obstruction will be absent. When the nasopharyngeal space is narrow, if it remains in an infantile stage of development, or if the space is diminished by the protrusion of the atlas, there will be inevitable crowding of the contents of the vault with definite symptoms of pressure.

Unilateral or bilateral hyperplasia of the tubal tonsils is significant because of its relationship to the ostiums of the pharyngeal tube. It is an insufficiently appreciated factor in the hearing impairment of older persons, although it frequently accounts for certain types of obstructive deafness in children. In all cases of hyperplasia of the nasopharyngeal and tubal tonsils there seems to be no relationship between the hyperplasia of these structures and the extent of development of the lymph nodes, the lymphatic tissue of the spleen, and Peyer's patches in the intestines. Also, there seems to be no correlation between hyperplasia of these structures in the nasopharynx, and the general pathological condition.

The fact that nasopharyngeal lymphoid tissue commonly recurs after attempted complete removal may suggest that this tissue possesses some definite function.

It is reasonable to assume that certain constitutional factors are responsible for variations in the development and involution of different parts of Waldeyer's ring. Why the involution comes earlier in certain individuals than in others cannot be satisfactorily explained.—*M.D.H., M.D.*

NERVE LIGATURE FOR PREVENTION OF AMPUTATION NEUROMA. M. A. Egorov. *Khirurgiya, No. 38, 1944.*

The prevention of neuromata in amputation stumps is still a problem. The known methods are not entirely satisfactory. The author had occasion to observe satisfactory results obtained by one of his former assistants, who used a massive ligature applied to the neurovascular stump. Following this method, the author ligated the nerves in the amputation stumps of twenty-seven children. He also cites a similar procedure in three amputations on adults. He emphasizes the comparative absence of phantom pain in the immediate postoperative period. Experimental ligations of the nerves were performed on fourteen dogs, and postoperative neuromata did not develop.

The author recommends the use of silk ligatures, applied tightly and separately to each severed nerve.—*E.D.M., M.D.*

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Washington-Nowata.....	J. V. Athey, Bartlesville	S. A. Lang, Nowata	Second Wednesday
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Visual Discomfort in Eye Workers Due to Glasses- -Some Causes and Cures

G. L. BERRY, M.D.
LAWTON, OKLAHOMA

Perfect or even useful vision may be impossible to obtain in a given case by means of refraction and glasses due to pathology or certain anatomical defects. But if the visual disturbance is either an anatomical or functional one in which the vision can be corrected or improved by lenses, the patient is entitled to comfortable vision. Equally deserving of eye comfort is that large group of eye workers who have normal vision as measured by the usual standards of refraction. Many of these, however, do not have comfortable vision.

A large majority of patients requesting examination by the ophthalmologist do so because of visual discomfort rather than for poor vision, yet the standard at which most refractions are aimed is visual acuity. But obtaining normal vision, or even better, does not in itself mean a good refraction unless the patient also obtains comfortable vision.

Many physicians making eye examinations have their own method of procedure. Their refraction method is a conglomerate one developed over a period of years originally starting as the method of some teacher but almost unrecognizable as such now. Some of these methods are not good, others are fair or average, still others are excellent as far as they go, but too many of our refraction procedures are incomplete in that they do not supply all the information necessary to make up a scientific prescription for glasses that will not only give vision as near perfect as possible but also make that vision comfortable.

It is not the purpose of this paper to describe pathology of the eye; neither is it within its scope to explain any one method

of obtaining satisfactory visual acuity. I shall not discuss anisometropia, although it is a frequent cause of discomfort. Neither shall I discuss cylophoria, except as it is induced by the patient's lenses.

I do hope to point out, and emphasize or re-emphasize, some of the more common causes of visual distress among those people, especially eye workers who do wear glasses for the correction of faulty vision, or visual discomfort. I shall also suggest the cure or the prevention for many of these conditions.

Since so many people complain of discomfort when they use their eyes for near work, it is evident that our refraction is not complete until it has found the cause of that complaint. Nor have we been successful in our treatment unless we have relieved that discomfort.

Poor vision itself is never uncomfortable. The nearly blind individual has no discomfort except that due to the inconvenience of not seeing well. The emmetrope with 20/20 or better vision may be very uncomfortable when he becomes an eye worker. The myope rarely has discomfort until he wears correcting lenses. He then becomes the equal of an emmetrope and subject to the same eye discomforts. Therefore, the cause of visual discomfort must be due to the use of the eyes rather than to the vision itself or the lack of it.

The causes of discomfort among eye workers may be many and varied. There is no single cause. If there were only one, it would have been discovered years ago and its cure standardized. Instead, there are as many causes as there are people who complain of it. First, let me mention that group due to

astigmatism as one of the most common. However, I shall not attempt to discuss it in this paper except to show its effect in certain cases when corrected by glasses. Poor reading habits are also a common cause of discomfort and there are many others I shall not even mention. Many are individual in application.

Those causes which I shall discuss, I have grouped for convenience under five headings:

1. Asynkinesis.
2. Low power of both accommodation and convergence.
3. Excessive power of both accommodation and convergence.
4. Lack of vertical balance between the two eyes.
5. Faulty glasses — which may even induce trouble or exaggerate a discomfort already present.

It is an established fact that convergence and accommodation normally work together in unison. Any demand for accommodation to act calls for a corresponding and equal action of convergence, and vice versa. If one or the other fails to respond to an equal degree, or if either is called upon to exert more power than the other, we have a condition of asynkinesis, and we have discomfort. For example; a 3.00 diopter must use 5 diopters of accommodation at 20 inches (3 diopters to overcome his hyperopia plus 2 diopters more to accommodate at 20 inches) but only 2 degrees of convergence are needed.

Many eye examinations are made without the power of the patient's accommodation being determined. This is especially true of those refractions made by ophthalmologists who routinely use a cycloplegic but do not make a thorough pre or post cycloplegic refraction. The power of accommodation cannot be measured while the action of the ciliary muscles is stopped by a cycloplegic.

On the other hand, we cannot assume that having normal accommodation means having normal convergence, as this function may also have any power from normal or above normal to a complete failure. My observations and records lead me to believe that the failure to measure the total convergence which our patient is capable of using, and the use of that information in the prescription for treatment, is one of the most common causes of discomfort in eye workers who wear glasses, second only to mal-measurement of the P.D.

Let me, at this time, emphasize a 'must' for the successful prescription of glasses. That is, the exact measurement of the interpupillary distance — the P.D. That measurement is anatomically and physiologically exact at a given distance and it must be so measured. No approximation will suffice, for

it is by this measurement that the optical centers of the lenses worn by the patient are determined.

In cases of excessive convergence we can, of course, hold it in abeyance somewhat by crowding the plus lens power (or by skimping the minus) to the point of just giving the patient 20/20 vision or in extreme cases not quite that good. But in those cases of convergence weakness, we have an entirely different problem. Just skimping the plus (or crowding the minus) to stimulate accommodation and likewise convergence is not enough. When convergence is weak, we must provide some assistance for it. This can be done in only two ways: First, orthoptics by prism exercises, the cost of which few patients will accept, and the home work in which few will persist long enough to insure results. The second means of assistance to convergence is by the use of fixed prisms in the lenses worn by the patient.

These fixed prisms may be actually ground into the lenses or they may be obtained by decentration of the lenses. This latter method of obtaining prism effect is limited, however, in its application by the power of the lens and other lens factors such as size and shape. Fixed prisms base in do relieve convergence insufficiency. They do not cure it. Probably an ideal treatment for weak convergence is a combination of fixed prisms in the lenses and orthoptics.

All patients who have a convergence weakness and who have a normal accommodation should have the benefit of a thorough physical and laboratory examination. Many of them are anemic; many have an active, undiscovered focus of infection; still more are mild hypothyroids. But regardless of the cause or the condition present, we must provide or maintain syknesis, a condition of balance between convergence and accommodation, or our patient will have visual discomfort, especially if he is an eye worker.

Vertical imbalances are often the cause of discomfort, but I shall reserve their discussion until later under the heading of faulty glasses, as it is almost impossible to separate those that are true hypo or hyperductions from those that are induced by the lenses worn by the patient.

Please allow me to digress a moment and explain one method of examination, which I think has enabled me to avoid many of the pitfalls of refraction technique.

You have perhaps noted that I have not used the term "phoria" in this paper. I rarely do. I much prefer the term "duction." Vertical is measured in terms of hypo or hyperduction. For the lateral muscles, I prefer the terms adduction and abduction. I often do the phoria tests as a matter of record during the examination for compari-

son purposes but I place no significance upon them. In fact, the lateral phoria tests are often very misleading. The duction tests, in my opinion, are far more accurate. I do not use the Maddox Rod at all except when I take a phoria test for comparison. It is a time-killing part of the examination and is confusing to many patients. I never depend too much on its findings, except perhaps for the vertical measurements where its results tally very closely with those of the duction tests.

I use a prism bar for all my muscle measurements and depend upon its findings entirely for both near and far tests. Its use is simple, fast and not confusing to even a four or five-year old child. I consider it the most accurate of all muscle tests, especially since its findings are always in harmony with those of the cover test. It is better than the Maddox Rod for it measures the total power of which the eye muscles are capable. It also enables me to measure both the power of accommodation and convergence at the punctum proximum at the same time. By this means we can determine the relationship of the two functions used together, as they must be when the eyes are actually at work.

In my opinion, no prescription for fixed prisms or orthoptics can be accurately based upon the findings of the Maddox Rod. It will indicate correctly most of the time but only that. The cover test is accurate and should precede the other test, but I am not sufficiently expert with it to make more than a qualitative diagnosis.

So much for the most common causes of discomfort inherent within the patient's own visual mechanism.

I now want to discuss and describe some of those causes of uncomfortable vision which result from the glasses worn by the patient. These are so numerous, and so many combinations are possible, that I shall only point out the more common ones. But it is my hope that these which I do describe may make us a little more careful when we write the prescription for a patient's glasses and more conscious of the necessity for the exact measurement of the P. D.

In this part of my paper I shall endeavor to illustrate some of the faults described, by giving case reports.

Vertical imbalance due to weak duction power is frequent and I think it is almost universally corrected by prism base up or down, if it is discovered at examination. But many, many patients have a normal vertical balance between the two eyes only to have a vertical imbalance inducted by the glasses worn for visual correction. This is especially

true of those with high corrections. How can this be? There are three ways: One, due to faulty grinding of the lenses. Second, one eye may be higher anatomically than the other without a corresponding decenteration of the lens. Third, the difference in the lens power before the two eyes may produce it when the patient looks down (or up) to read or work.

Case Report: Bookkeeper, 36 years old. Worn glasses about 10 years. Last pair — one year and never comfortable. Headache every day. Old glasses Rx., Rt. plus 3.00, Left plus 2.50-50x180. Lens center 60mm and lever horizontally. The refraction was found to be correct. The P. D. 60. The accommodation normal for his age. Ductions all normal. Examination showed the left eye to be 4mm higher than the right. This gave in his old glasses a vertical imbalance of $1\frac{1}{2}$ prism diopters when he looked down 6mm below center while at work.

A new left lens using the same Rx., of plus 2.50-50x180 — but with the lens center decentered up 6mm — gave him perfect balance at his working position. His discomfort entirely disappeared.

Case Report: Stenographer, 18 years old. Worn glasses six months since beginning present position. Has P. M. headaches, eyes smart and burn. No Sunday distress. Reads very little. Old glasses Rx., Rt. plus .75, Left plus .25-1.00x180. Vision 20/20 with glasses. P. D. 62. Accommodation and ductions normal. These glasses induced almost one degree prism vertical imbalance when looking down at work (6mm below centers).

This case was treated by supplying her with slip-overs with one-half degree prism B. U. over left eye and one-half degree prism B. D. over the right eye for temporary wear over her old glasses — while working only. She has had no discomfort since using the slip-overs.

Many people can easily tolerate one degree prism of vertical imbalance, but those who can't are very uncomfortable with it.

I see many patients having visual discomfort due to the effect of the lenses when the eyes are unequal distance from the mid-nasal line (or have an esymmetrical nasal bridge). Different lens power over the two eyes also applies here as in the vertical but the result is not so marked.

The answer to this latter problem is the same as that of the vertical, that is, decentration of the lenses so that their centers correspond to the two eyes. One has only to prevent prism base out effect in the horizontal plane. Many will not have actual discomfort and will only discover that all was not

well when they find their new glasses are more comfortable. Very few eye workers can have comfortable vision when they must overcome even a small amount of prism base out while they work.

There is one condition that is rather common and always causes base out prism effect unless it is compensated for. That is, the base out effect of a cylinder used to correct astigmatism. If the cylinder is a minus one, axis 90 and the net power of the lens is minus in that axis, there will be prism base out unless the lens centers are exactly over the near P. D. or outside of it. Also any minus cylinder whose axis is between 90 and 180 over the right eye, or between 90 and 0 over the left eye, produces a prism base out effect. Conversely a minus cylinder axis 90 to 0 over the right and 90 to 180 over the left eye gives a prism base in and down effect. The action of plus cylinders is, of course, the opposite for all positions. So a minus in the lens, would induce prism base out in any prescription unless compensated for by lens decentration or by a compensating fixed prism base in.

While still on the subject of astigmatism correction, I would mention cylinders with oblique axis as producing still another discomfort. Unless the axis is exact, artificial cyclophoria is induced. If the axis of both cylinders are misplaced in opposite direction, that is, both away from or both towards 90, the effect is increased. A patient may tolerate without discomfort a small amount of natural cyclophoria but would have marked distress with the same amount induced by the lenses worn.

Every refractionist sees many many cases of weak convergence every day. Patients with low accommodation due to spasm or ciliary weakness are also a daily problem. Those with excessive power of both convergence and accommodation are not at all uncommon. And all of these have discomfort of one kind or another but nothing compared to the distress suffered by those patients who have both a low convergence power and a low accommodation.

Many of these latter types have even changed occupations because of so-called "eye-strain." They usually describe their trouble by saying their eyes are "weak," they have had to quit reading and all close work. They complain of headaches, dizziness, aching in their eyes and often of pain when forced to look at something very close to them. Giving them increased plus only diminishes the convergence effort. It is only by fitting them with two pairs of glasses, or by using bifocals with prism base in the seg, can these eye workers have comfort. They will not tolerate enough prism in the distance lens to give comfort at near.

Case Report: Auto Salesman, 45 years old. Some bookkeeping, a very prolific reader. Has had discomfort with every pair of glasses he has had. Began wearing glasses at about age 38. Has had eight or ten pairs of glasses. Eyes dilated at three of those examinations. Last pair of glasses three months old with a Rx., of Rt. plus 1.50-.50x90, Left plus 1.50-.25x180. Add plus 1.25 O. U. Lens centers distance 64mm, near 60mm, and centers level.

My examination showed the P. D. to be 60 at near. The left eye 3mm higher than right and 2mm farther out from mid-line than right. My manifest findings about the same as old glasses — Rt. plus 1.75-.50x90, Left plus 1.50-.50x10. He has one degree hyperphoria left eye and his convergence was very weak. He needed 3 degrees prism base in to fuse at his punctum proximum. His accommodation was one-half diopter low for his age.

I prescribed for him as follows: Rt. plus 1.75-.50x90, Left plus 1.50-.50x10 with an add plus 1.75 O. U. together with one and one-half degrees of prism base in O. U. and one-half degree prism B. D. left. The distance lenses were centered at the near P. D. so I could inset the segs still more and thus obtain a little more prism effect at near.

He wore these for two years. They were better than his old glasses but not comfortable at any time. The prism bothered his distance vision at times when driving. So two years later I had made up for him a pair using the same prescription with the same centers and the same decentrations to be exactly over the eyes. But in these, I only put one degree prism base in O. U. in the distance and put one and one-half degree prism base in each seg.

These glasses gave him marked relief from distress, and he now reads and works with comfort. This patient had previously had many hours of orthoptics with no improvement so I did not even propose such a procedure. Correction of all the abnormalities plus general support to convergence was not enough in this case. He only obtained comfort when support was given both convergence and accommodation at his near point, all other factors remaining the same.

I see more cases of visual discomfort produced by untreated weak convergences than from all other causes combined. Many have had frequent lens changes over a period of years without relief. Many have flitted from oculist to optometrist and back again many times only to wear each pair of glasses for a few months. And so it goes. They are discomfort cases and will always be until someone gives them a little support to their convergence.

Personally, for weak convergence cases I prefer fixed prisms plus simple convergence exercises by the patient at home, and I fail to find that they require more prism later, unless the original cause of the weakness remains untreated. I insist that they have a general examination and are treated if necessary. If the B. M. R. is normal or below, I routinely give small doses of thyroid to these low convergence cases.

There is one group of convergence cases that are very common. They have no complaint of pain or headache, but they are not happy with their glasses. They are the patients who have their glasses "out of line" all the time. They worry the doctors and his assistant, or the dispensing optician, almost to distraction. They demand re-examination and never know what is wrong. They are constantly pulling or pushing on their glasses, always wiping the lenses to remove any imaginary speck of dust. In other words, everything is wrong with their glasses except the vision. I have given this group the name of "Fiddlers" for they are always fiddling with their glasses.

The cure of this fiddling is fairly easy. A little base in prism effect in their lenses, plus small doses of thyroid daily, will produce a miracle.

Case Report: Housewife, 47 years old. Worn glasses 16 years. Has had 12 lens changes. Complains of glasses not fitting, says she has them adjusted by the doctor every week. Present glasses 3 months old. During conversation "fiddled" with glasses several times. Present Rx., plus 1.00 add plus 1.50 O. U. centers 62 and level. My refraction, P. D. 62. Eyes level and equal from midline. Rx., Rt. plus 1.00, Left plus 1.25, add plus 1.50 abduction 6D adduction 8D. Vertical ductions equal. Accommodations normal for age (13 inches), near convergence — just able to fuse at punctum proximum (2D. prism base out caused diplopia).

I changed her lenses and gave her one diopter prism base in each eye and prescribed $\frac{1}{2}$ grain thyroid twice daily. She is happy, and I have only adjusted the alignment of her glasses twice during the last year.

Low power of accommodation will always produce discomfort if the patient must use his eyes for near work, unless the accommodation is measured and the deficiency provided for. But just making him emmetropic by lenses to correct the evident hyperopia does not always relieve the discomfort. The accommodative difficulty may still remain in part, due to spasm of accommodation or to ciliary underdevelopment.

We cannot accept every case which fails

to show a normal accommodation as being one due to spasm or latent hyperopia. Many of them are due to ciliary weakness or underdevelopment. If due to spasm, our cycloplegic examination will reveal the true total. These can usually be relieved by partially or completely correcting the latent hyperopia. But those cases of ciliary underdevelopment continue to have discomfort until someone measures their total power of accommodation and gives them bifocals. The diagnosis of this condition must be made from the manifest findings when the total power can be measured at the punctum proximum. The cycloplegic examination will not reveal it, for these findings are static and will be the same as the manifest findings. So unless we know from our manifest the total power the patient has, our prescription will be only partially adequate.

Case Report: School-girl, age 12. Has headaches almost every P. M. at school — often beginning before noon. Fair grades — is poor reader. Worn glasses 6 years. Has had glasses changed 7 times — 5 examinations were made with drops in the eyes. Still has 3 pairs of glasses besides her present ones. Present Rx., is Rt. plus 3.25, Left plus 3.50 (all of her old glasses were within .50D. of this same Rx.) Her vision with glasses is 20/20.

My examination showed the following: Manifest Rt. plus 3.25, Left plus 3.25. Near P. D. 56. Ductions all normal at distance. Accommodation at 4 inches (the punctum proximum which is practical under 20 years) shy plus 3.00 D. Convergence at near was normal with the accommodative add before her eyes. Cycloplegic examination (atropine) gave about the same findings — Rt. plus 3.75, Left plus 3.50. Her general examination was entirely negative.

This being the case of ciliary underdevelopment, I prescribed her glasses as follows: Rt. plus 3.25, Left plus 3.25 — with a bifocal reading add of plus 2.50. This, by post cycloplegic examination with her glasses, showed her to have a punctum proximum at 10 inches, therefore, she now had 4 diopters of accommodation. She uses 3 diopters at 13 or 14 inches so she has adequate power for comfort (not the normal amount for her age, however). She is still wearing the same glasses after two years and is comfortable. Her reading is excellent and her school grades are above average.

Accommodative discomfort always results when the patient has no reserve. A person 45 years old should have 3 diopters of accommodation, that is, punctum proximum should, according to Donder's Rule, be at 13 inches. It takes 3 diopters accommodation to see clearly at 13 inches, so an emmetrope may

be able to see at 13 or 14 inch working distance, but he will have to use all the accommodation he has. That means discomfort. He should have one diopter more in his glasses so that he will have some reserve.

Case Report: School-teacher, age 45 years. Worn glasses six years. Last pair are bifocals. Complains of headache every afternoon and evening — eyes feel tired. Her present glasses Rx., was plus 1.00 O. U. with a presbyopic add of plus 1.50 O. U.

Examination showed her vision with old glasses to be 20/20 (same without glasses), but her punctum proximum with these lenses was at 14 inches. The centers were satisfactory. Her ductions were all normal. My examination gave her manifest Rx., at Rt. plus 2.00, Left plus 2.50. Then a plus 1.50 add brought her punctum proximum up to 10 inches so that at her working and reading distance of 13 to 14 inches, she had one diopter of accommodation in reserve.

She has been comfortable with this prescription. Her old glasses undercorrecting her for distance barely gave her the needed net accommodation for her work with no reserve.

The wrong type of bifocal segment may produce discomfort in a presbyopic eye worker due to too much prism base up or down causing positional discomfort. Or there may even be some prism distortion. A minus lens combined with a round seg of high power induces marked prism base down effect. A plus lens of medium or high power combined with a round seg will tend to produce little or no prism. Likewise a minus lens with a straight top seg tends to neutralize the prism effect for their bases are opposite.

Again the seg may introduce trouble or exaggerate it if the optical center of the seg is outside the visual axis of the eyes at their working distance by inducing undesirable prism effect. For the same reason discomfort is caused very easily when the power of the distance lens is greater than the power of the seg. In this case there may be no optical center in the seg itself. There may be only prism base out and no one can tolerate base out prism with comfort for constant wear at near.

Earlier in this paper I stated that in my opinion wrong P. D. measurement is the most common cause of discomfort among eye workers who wear glasses. I could give case reports of this kind by the dozens, but shall only give a typical one to illustrate this fault. If the P. D. measurement is inaccurately made, the lens centers will be inaccurate. If the centers are inaccurate, that is, not in the line of the visual axis, prism is introduced by the lenses. Unfortunately the most common mistake is a too wide P. D. so the resulting

lens error introduced is prism base out if the patient wears plus lenses.

Case Report: Mrs. S., Housewife, age 30 years. Reads and sews about six hours a day. Complains of headache and a burning and itching discomfort when using eyes. Old glasses 2 years. Rx., Rt. plus 2.50-2.50x5, Left plus 2.50-2.50x1 $\frac{1}{2}$. Lens centers 62 — vision 20/20 with glasses. Also has a pair of calobar glasses with the same prescription which are comfortable. These are worn regularly for driving and all out-of-door use. My examination showed the P. D. to be 62 at distance and 58 near. The prescription of her old glasses was correct and the axis of the cylinders was right. Her ductions were all relatively weak (below normal).

In this case the P. D. was evidently measured for distance which was satisfactory for her driving glasses, but the same measurement gave her one-half degree prism base out over each eye at her reading and sewing. She could not tolerate it with comfort. New lenses, having the same Rx., of Rt. plus 2.50-2.50x5, Left plus 2.50-1.50x1 $\frac{1}{2}$ — but with the centers brought in to 58mm, gave her complete relief so that she is comfortable with no headaches or burning when she uses her eyes.

Prism base out stimulates accommodation and produces spasm of the ciliary mechanism. Figure what happens when a patient wearing a plus 4.00 diopter correction is measured 5mm too wide for the P. D. at his working distance. Uncomfortable? Try it yourself sometime for 30 minutes while you read.

The last group of discomfort causes I shall describe are those due to or introduced by the optician as the lenses are ground in the shop. The most common of these are inaccurate centers in the lenses.

Case Report: Housewife and bookkeeper, age 30 years. Old glasses worn for five years (are now lost). Has had headache almost every afternoon for past year — worse now since without glasses.

My refraction showed Rt. plus 2.50-3.50x7, Left plus 1.50-2.50x1 $\frac{1}{2}$. The P. D. was 58 at near. Her ductions were all low normal. I prescribed glasses according to the above findings. I failed to check the glasses when I received them from the optician and delivered them to the patient as they were.

About a month later she returned, complaining of afternoon headaches worse if using eyes and a marked distress in eyes all the time. I then checked the lenses and found the prescription to be correct but the centers 65mm instead of 58 as ordered. This gave her one and one-half diopters of prism base

out over the two eyes at near. New lenses with correct centers were orderd for her. Since then she has had no discomfort and no headache.

But often glasses that come out of the shop not right, are not entirely the optician's fault. He must grind lenses and mount them in frames from the prescription that we send him. He can guess at a lot, but unless our prescription contains enough information for him to know what we want, he can only grind the lenses. He cannot compose a pair of glasses to fit the needs of any particular patient.

Also he cannot grind a compensating prism in a lens unless we tell him to do so. He cannot give us centers of 55mm in a pair of glasses with 46x40 lenses with a 24 between, unless we instruct him to grind prism to bring the centers in, due to the fact that blanks now-a-days are usually only 50mm in diameter and the most he could decenter would be 4mm each lens. If we ophthalmologists would work out our problem far enough to be able to give the optician the information as to the end results we must have, and instruct him to get those results, he will do the mathematics necessary and we would have many less discomfort cases.

In conclusion, let me summarize by re-emphasizing that discomfort cases among eye workers are often due to or aggravated by the lenses worn for the relief of visual distress. Most, if not all, of this discomfort can be relieved or cured by a thorough refraction and accurately prescribed glasses.

We must measure the P. D. accurately for the distance at which the patient works, and we must be sure that the centers of the finished lenses conform to that measurement. We must be sure that no undesirable prism effects are introduced by the lenses.

We must provide some assistance for weak convergence, either in the form of orthoptic training or by the use of fixed prisms in the lenses prescribed. Or we can use both methods, but we must, by whatever means we employ, obtain synkinesis if we are to give our patient the best possible refraction and comfortable vision.

We must provide adequate accommodation so that our eye workers will not only have a sufficient amount for clear vision at his working distance, but will also have a reserve which will, under his normal working conditions, not be needed. This reserve should at least be equal to one-third of his total, or he must have not less than one diopter of reserve accommodation.

We must have sufficient knowledge of mechanical optics (as well as physiological op-

tics) to be able to detect and avoid undesirable lens effects and plan for desirable ones so that our instructions to the optician will be definite and complete. We must plan a pair of glasses much the same as an architect plans a building. They must fit the needs of the individual who wears them. Unless we are able to plan them both mechanically and physiologically to fit his needs, we have failed to give our patient a scientific prescription and treatment. We have only sold him a pair of glasses.

We must individualize every refraction. Every patient has different needs and requirements which must be considered and met. But there are certain broad principles which apply to all problems of refraction if we are to give our patients comfortable vision. These are:

1. Accurate P. D. measurement for the distance at which the patient works.
2. Provide support for weak convergence.
3. Provide adequate power of accommodation with some reserve.
4. Endeavor to provide for equality of effort between accommodation and convergence and obtain vertical muscle balance.

J. Marion Sims

Justly held as the father of gynecology, his genius knew none of the limitations of specialization, and in my opinion his most notable contribution to science is his paper on "The Careful Aseptic Invasion of the Peritoneal Cavity, Not Only for the Arrest of Hemorrhage, the Suture of Intestinal Wounds, and the Cleansing of the Peritoneal Cavity but for all Intra-peritoneal Conditions," Read before the New York Academy of Medicine, October 6, 1881. It marked the dawn of an era, and was the real starting-point in the new surgery of the abdominal cavity.—*John Allan Wyeth. With Sabre and Scalpel.* p. 371. 1924.

SIR ALEXANDER FLEMING HONORED ON JULY 3 RADIO PROGRAM TRIBUTE

NEW YORK—Sir Alexander Fleming, discoverer of penicillin, was among the outstanding men of medicine appearing as distinguished guests in the current radio series, "The Doctor Fights."

Dedicated to physicians and surgeons serving both in the armed forces and on the home front, the Schenley Laboratories program (CBS, Tuesday, 9:30 p.m., EWT) dramatizes actual episodes of medical heroism and achievement on battle fronts, aboard fighting ships and in the laboratories and hospitals where crucial victories in the field of medicine and surgery have been won. Each week, the doctor whose real-life achievements provide the theme for the broadcast participates as guest of honor.

Sir Alexander came before the microphone July 3 when the radio series reenacted the dramatic events leading to the world famous British scientist's first realization that something secreted by an unwanted mold was mysteriously dissolving cultures of deadly bacteria in his London laboratory. Now visiting in the United States, Sir Alexander is surveying progress of American industry in producing the temperamental penicillin on a commercial scale and studying recent research in the clinical use of the "miracle drug."

Actinomycosis*

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Actinomycosis is still a relatively rare infection, Sanford having collected 678 cases in the United States prior to 1923.

At John Gaston Hospital in Memphis there have been 14 cases since 1920, at University Hospital in Nashville 46 cases between 1926 and 1936. In St. Anthony's Hospital there have been 9 cases. But the fact that the diagnosis may often have been overlooked must be considered since only 10 of the 14 cases at the John Gaston Hospital had been previously diagnosed correctly.

Actinomycosis is found in all parts of the United States and Canada, but is most common in the Mississippi valley and northeastern United States with New York and Massachusetts predominating. However, it is probable that this greater prevalence of the disease in any one locality is only apparent and may be due to greater interest in and familiarity with the disease in that particular locality.

ETIOLOGY

As to the etiology of actinomycosis for the past 30 years two different views have been prevalent concerning the mode of infection. On the one side, there are those who believe that the organism gains entrance to the body through grasses and grains etc. upon which the organisms live in the outside world and by means of which the infection is carried. Contact with "Lumpy Jaw" in animals is also considered a source of infection. The theory with reference to grasses and grains is also supported by the fact that many cases are reported in which barbs of barley or grain have been found in the lesions of men and animals and many instances in which there is a history of swallowing blades of grass.

The followers of this theory also take the reports of instances of endemic actinomycosis among cattle fed on certain fields of grain as further evidence.

There is an opposing theory based on the well known and accepted works of Israel and Wolff demonstrating that the organism causing true actinomycotic lesions never grows

on grasses or grains and has quite different cultural characteristics from the aerobic organism found widespread in nature, upon grasses and grains. Actinomycosis bovis is a facultative anaerobe, difficult to grow, and grown only at body temperature. These facts have given rise to the view upheld by Wolff and Israel that actinomycosis bovis does not have its usual habitat in the outside world on grain and grasses, but normally inhabits the digestive tract where it remains as a saprophyte. Given the proper conditions of a lowered resistance and portal of entry, the organism becomes pathogenic with the production of a lesion. Furthermore, the organism has been cultured from the mouths of normal individuals with the subsequent production of typical actinomycotic lesions in animals.

It is commonly stated that the disease is more common in those handling hay or those who come in contact with animals afflicted with lumpy jaw. However in reviewing the reports with this particular point in mind, it would seem that the actual facts do not substantiate this generally accepted impression.

Sanford reported 119 cases from the Mayo clinic and found only 16 of these to be farmers. In his 678 collected cases only 40 per cent were found to have been in contact with cattle or in occupations which predisposed them to infection. Furthermore, there was no definite relationship between the distribution of the disease in the entire country and its occurrence among cattle.

In the light of recent experiment the most probable source of infection is the oral cavity where these parasitic actinomycoetes grow and become pathogenic when the proper conditions arise. What these conditions are no one knows, but from the fact that foreign bodies are frequently found in actinomycotic lesions, it is evident that trauma sometimes plays an important part.

ANATOMICAL DISTRIBUTION

Cervical cases are the commonest type with approximately 60 per cent of the cases occurring in this region. About 20 per cent are abdominal and 15 per cent thoracic though any part of the body may be affected.

*Received for publication 1944.

The yellowish-gray masses of gungi in the discharge should serve to differentiate the cervico-facial cases from tuberculosis, sarcoma, or syphilis, though at times the organisms are very difficult to locate ever after long and diligent searching.

When the infection is primary in the lungs it usually begins in the lower lobes. It spreads by direct extension involving all structures and tissues in its path. This results in eventual involvement of pleural surfaces and chest wall with formation or discharging sinuses in the skin of the thorax.

Mycotic infections of the lungs are important clinically because of the close resemblance to tuberculosis. Though relatively rare, the disease probably occurs much more frequently than statistics would indicate—many mycotic pulmonary infections are erroneously called tuberculosis. When no tubercle bacilli can be found in the sputum, actinomycosis must be seriously considered. The symptoms and physical signs so closely resemble pulmonary tuberculosis that only the absence of acid fast organisms and persistent presence of fungi in the sputum can indicate the true origin of the disease. Though mycotic infections may be primary in and limited to the lungs, they are usually accompanied by, or secondary to, lesions in the skin or bones. Hence the presence of unusual skin lesions or discharging ulcers should arouse the suspicion of a pulmonary mucosis when the etiology of a chronic lung abscess is in doubt.

Of the abdominal cases the ileo-cecal region is the most often affected and the diagnosis of appendicitis is frequently made. Operation reveals the inflammatory masses involving the appendiceal region and an indolent draining sinus may result. In those cases which are not properly treated surgically, tumor-like growths and multiple abscesses involving any of the abdominal organs or tissues may lead to rupture through the skin or invasion may take posteriorly through the peritoneum into the kidneys.

PROGNOSIS

The prognosis varies with the extent and site of the lesion. Approximately one-half of the patients with abdominal involvement recover. The pulmonary type may be fatal within a year. The cervico-facial type however, has a much better prognosis, with about 75 per cent recovery.

TREATMENT

General supportive measures such as rest, fresh air, sunlight, with a high vitamin, high caloric diet should be provided from the first.

It is quite generally agreed in the past that the treatment has been quite unsatisfactory. Many different forms have been tried. A few of these are: 1) Radical Surgery, 2) Roentgenotherapy, 3) Iodides, 4) Copper sul-

fate, 5) Colloidal gold, 6) Insulin and I.V. glucose in an attempt to elevate the B.M.R., 7) Autogenous vaccine, 8) Non specific protein therapy, 9) Thymol by mouth and locally.

Graham states that if the lesion is small, it may be completely excised. Abscessed sinuses, and fistulas should be incised, curetted and drained and the cavities treated with tincture of iodine.

Wangensteen was able to find only one case of pulmonary actinomycosis recovering after X-ray therapy, but collected reports of 19 cases recovering after surgery. Surgery, he believes, should be extensive enough if possible, to remove all infected and dead tissue.

E. E. Wilkinson of Nashville reported a case of an 11 year old girl with actinomycosis of the face, chest wall, and dorsum of the foot. X-ray examination revealed heavy infiltration of the region of the right hilus. She was given sulfanilamide .6 Gm every 4 hours for a total of 83 days at the end of which time all of the lesions and chest involvement had almost completely disappeared.

Review of the recent literature reveals the extensive use of sulfanilamides with fairly favorable results. The response is slow and the drug must be continued over a long period of time. Cases failing to respond to sulfanilamides frequently are improved by iodine therapy and vice-versa, but to date these two drugs appear to be the most efficacious agents we have in the treatment of actinomycosis.

This is the case of Mr. J. L., white male, age 18 years.

This man was first seen in this hospital on 4-2-42 at which time he was complaining of pain and swelling in the right costovertebral angle posteriorly. History revealed that he had been operated on for a ruptured appendix on 9-6-41. He left the hospital on 10-5-41 and enjoyed good health until around the first of December when he began having a pain in his right side. This pain was described as being dull aching in character located just below the rib margin posteriorly and did not radiate. He began losing weight and had lost 30 pounds prior to his admission and has been running a low grade fever since onset.

About the first of February he noticed a swelling in the affected area. The swelling continued to increased in size, but he thought that the pain had decreased in severity.

Physical examination revealed an emaciated 18 year old white male appearing to be chronically ill.

Lungs were clear and resonant throughout.

A swelling was present in the right costo-

vertebral angle posteriorly measuring approximately 3x4 inches which was hyperemic and fluctuant.

Blood count revealed R.B.C., 3,290,000 with 60 per cent hemoglobin. W.B.C. of 14,200 with 79 per cent neutrophils.

Temperature at time of admission was 102 degrees.

On 4-3-42 an incision was made posteriorly along the level of the twelfth rib posteriorly and a moderate amount of translucent fluid was obtained. Repeated cultures and smears were negative.

The incision continued to drain and the patient ran a low grade temperature for the next month and then began having daily temperature readings of 102 degrees—103 degrees, with W.B.C. of 15,400.

On 6-19-42 he was taken to N. Surgery when an incision 5 inches in length was made at the site of the former drainage. A large amount of chronic inflammatory tissue was encountered and several tracts were found leading out into the abdominal cavity. No distinct abscess cavity was definable. Biopsies were taken from the inflammatory mass and a portion of the twelfth rib. The peritoneal cavity was not opened. Incision was packed with iodoform gauze and 6 Gms. of sulfanilamide powder was placed in the wound.

Tissue examination revealed necrotic granulation tissue and possible hypernephroma.

Biopsy of bone was diagnosed as osteomyelitis. No organisms were identified.

X-ray examination of the lungs, G.I. and G.U. tracts revealed no pathology.

The incision was dressed daily and iodoform gauze placed in the drainage site. Patient was given repeated blood transfusions and supportive therapy. His general condition improved and the incision filled in nicely.

He was discharged on 8-3-42 in an improved condition, but with some drainage still coming from the incisional site.

Patient was readmitted on 9-13-42 in a critical condition. For the past seven days prior to admission he had been having chills and high fever.

Physical examination revealed increased breath sounds bilaterally with numerous moist rales. The incision was still draining a small amount of clear fluid.

He ran daily septic temperature of 105 degrees in the afternoon and normal at night.

Repeated blood cultures and lamaria smears were negative.

He was given transfusions, sulfadiazine and general supportive treatment. His condition became worse and on 9-18-42 he expired.

Autopsy revealed generalized actinomycosis involving 1) Skin, 2) 12th rib, 3) Liver, 4) Parapancreatic lymph nodes, 5) Lungs, 6) Spleen, 7) Right kidney.

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SPECIAL ARTICLE

MODERN MEDICINE IN MODERN CHINA A CHALLENGE

LEWIS J. MOORMAN, M.D.
OKLAHOMA CITY, OKLAHOMA

A careful perusal of A Nation's Vigil¹ indicates that China is undergoing a great social and mechanistic revolution which will be greatly accelerated when the war with Japan is over and the "Dwarf Monkeys" are put in their place. John Gunther² sensed the passing of the old China when in 1939 he wrote: "And China, old as Japan is young, charming as Japan is crude, amiable as Japan is sinister, cultivated and gracious as Japan is dynamic and efficient, is in the grip of a convulsion partly of disintegration, partly of rebirth. The Chinese, surviving a terrific ordeal, are in a state of metamorphosis."

Before we dare dream of the regeneration of China even in the field of medicine, we must remember that China has many domestic, racial and intellectual qualities which we would do well to emulate and which we hope she will never relinquish. According to Chinese annals, their civilization antedates all others. The unbroken continuity of this civilization is worthy of serious contemplation. The medical works of Shan Nung, the father of Chinese medicine, dates back to 2700 B. C. A standard medical work by Wong Tai appearing in 2697 B. C. Their greatest surgeon, Wa To, lived about 200 A. D., probably contemporary with Galen and Aretaeus. Chinese legend has it that he attempted even neurosurgical procedures and, in recommending such an operation to restore the health of a high government official, he was accused of treason and summarily executed.

In 1916 Welch³ said, "The ancient Chinese medicine has continued practically to be the basis of their accepted views of the nature and treatment of disease up to the present day. I can imagine nothing comparable to the unchanged and unchanging character of their medical ideas." Compared with their knowledge of anatomy and physiology their methods of diagnosis were relatively good. Their description of smallpox was on record nine hundred years before the disease was recognized in the West. Their imperical materia medica was remarkable when compared to that in other parts of the world.

The following from Welch³ throws light upon their therapy. "We were much inter-

ested in the shops and booths of the Chinese doctors in the public squares of Nanking, where we had gone to see the Confucian temple. There were dried roots, stems and leaves, snake skins, toad skins and bones of animals—particularly tiger bones, which are ground up and used as a tonic. They have an old distinctive procedure in the use of moxa as a cautery—the leaves and stems of the *artemisia moxa* are ground up and made into little conical pastilles which are fired and burn the skin; in the dispensaries nearly all the Chinese I saw had scars where moxa had been applied. They also use the actual cautery. But peculiarly distinctive of the Chinese method of treatment is their needling—acupuncture—which is used as a counter-irritant. It is done on all parts of the body, and the missionaries tell distressing stories of the effects of these punctures in certain locations, for even the eye is needled if a person complains of a pain in that organ."

Before the introduction of modern medical education in China the title of doctor was handed down from father to son and a long line of medical ancestors was considered highly desirable. In 1915 at Shanghai, Welch,⁴ representing the Rockefeller Foundation, said: "We have come to China not to impart information to you but to carry some knowledge of China away with us. We shall take away much more information than we shall leave."

Welch was in China for the purpose of forwarding and cementing interest in modern medical education then accentuated by "Yale in China" located at Chagsha, Hunan. Addressing the students and faculty at the Sunday morning chapel service, October 17, 1915, he made the following significant statement: "And to you, young men of the Faculty, for you are young from my point of view: I think that your life is a most enviable one. No sympathy from me, only envy; for you have here a larger opportunity for service and of gaining the real mental, moral and spiritual satisfactions of life than most of you would be likely to find in America. I am going back with a message to the young men at Hopkins. Why do so many eke out their lives amidst the unsatisfactory environ-

ment and the meager opportunities that come to most of them? If they have intellectual curiosity, something of the spirit of adventure, desire to advance medical knowledge, desire for beneficent service, where can any opportunity make a stronger appeal than that here in China today, especially in the development of modern medical science and practice in China? You must feel the enthusiasm and inspiration of the opportunity, and be eager to be provided with the staff and the equipment to meet the opportunity you see before you."

No doubt this country's efforts toward medical education in China has had much to do with her present stride toward Western civilization. Welch⁴ anticipated this when he said, "Modern medicine means far more than the care of the sick and wounded, important as that is. It touches all phases of society. It has a broad and liberalizing effect on education. No wonder all the workers in hygiene and social reform have grasped in a peculiar way the significance of modern medicine for the uplift of society and the progress of civilization. Our great modern cities, for instance, could not exist without the help of modern medical science. You could not live here in Shanghai without the knowledge and power that has been placed in Dr. Stanley's hands to stay pestilence and to promote conditions of healthy living. The indirect benefits to be expected from the introduction of the best medical education and of the science and art of modern medicine into China are far reaching, relating as they do to other departments of education and knowledge and to fundamental problems of industry and of society."

Knowledge of Western medicine first came through medical missionaries. The superiority of our medical care was not particularly impressive but the Chinese, always backward in surgery, were greatly intrigued and inspired by Western methods in this, the most spectacular of all the healing arts. In the early part of the 20th Century, modern Chinese doctors were beginning to appear. A few were educated in America and European countries, but many more in the inferior Japanese medical schools where Western methods were imperfectly taught. Already Western medicine was being taught in China chiefly through the missionary schools. None of these facilities were fully meeting the needs.

With these conditions prominently in the picture, The Rockefeller Foundation and the China Medical Board planned to take over the then existing Union Medical College in Peking and to establish a second medical school in Shanghai.

Though more than 30 years have elapsed since these efforts were initiated, we find that before the present war China had a ratio of only one doctor to 50,000 people.⁴ Looking through successive issues of the Chinese Medical Journal, one is impressed with the importance of nutritional needs and vitamin deficiencies⁵ with beri-beri leading the great army of the underfed, and falling next in line is "vitamin A deficiency in the form of night-blindness, keratosis of the skin and keratomalacia and ariboflavinosis in the form of cheilosis, glossitis, seborrheic dermatitis (Hou. 2) and eye lesions (Hou. 3). Other deficiency diseases of less frequent occurrence are pellagra, nutritional edema, scurvy and rickets."

Significantly connected with the problems of nutrition in China is the high infant mortality, quoting from M. Y. Cheng,⁶ "The infant mortality of those babies, whose mothers had antenatal examinations, was only 82.0, as compared with that of 149.1 for those who had none. . . . The mortality rate of those infants delivered by western-trained physicians or midwives was 72.9, as compared with 154.7 among those delivered by old-type midwives or relatives. The latter type of delivery occurs in over 80 per cent of all births in China, resulting in a mortality rate of 8 out of every 10 neo-natal deaths due to tetanus neonatorum. Infant mortality could be very greatly reduced if scientific methods were used at delivery. . . . The mortality of artificially-fed infants was three to four times higher (421.6) than that of breast-fed infants (212.5). Fortunately, 98 per cent of Chengtu infants appear to be breast fed, as adequate substitutes for breast milk are exceedingly difficult and expensive to obtain.

. . . Infant mortality is one of the best indicators of the health and social progress of a community. The findings of this survey bear this out very strongly. The infants from well-to-do homes, with educated parents and with fathers in good occupations, showed a mortality only one-fifth of that from the poor, uneducated and lower classes of society. Where the mother had received higher education, this figure was reduced to less than one-tenth. . . . Neo-natal mortality (infants under one month) was found to be 51.4 per 1,000 living births, or 40.7 per cent of total infant deaths. Deaths under two weeks, when untrained midwives or helpers delivered the baby, were 7 times as frequent as when western methods were used, while deaths under one month were 5 times as high, thus showing the very great effect of the type of obstetrical service on neo-natal deaths. Of the 235 total deaths under one month, only 16 occurred after scientific obstetrical care, with no case of tetanus; 219 occurred when

no scientific methods had been used, with 193 cases of tetanus, i.e., 80 per cent of total neo-natal deaths."

All the above conditions have been aggravated by the sustained strain and stress of the long continued war with Japan, but this only emphasizes China's need of help in her efforts to develop adequate medical care as a background for the rapid progress these indomitable people are sure to experience.

If Welch could see the scientific contributions to modern medicine now coming from Chinese Doctors, he would be proud of his part in the establishment of modern medical education in China but he would no doubt renew his appeal to young men in our medical schools to avail themselves of the larger opportunities offered through China's present needs for more adequate modern medical care.

When the war is over and the cards are shuffled in the light of our narrowed horizons and our mounting international opportunities and responsibilities we should be ready to give to China and to receive from her everything that is mutually good in medicine. This is something the American Medical Association, the Council on Medical Education, medical schools, and medical and philanthropic foundations should take seriously to heart.

Donald M. Nelson^s has said, "China has become one of the Big Powers. This fact not only affects the fate and future condition of Asia but is of tremendous importance in our own lives in America. . . . The industrialization of China is not China's problem solely; it is our own. For we also are going to have to live in a postwar world."

Mr. Nelson indicated that China will not need or want charity but that extending help will amount to good business for the United States. He might have said that industrial success in China will depend largely upon the health of the Chinese people, that the health of the people will depend upon better medical care, that better medical care can come only through a more adequate supply of scientific doctors and that this need can be met only through increased facilities for modern medical education inside China in the United States and in Europe.

If the people of the United States knew what American Medicine as a free enterprise has done to prepare the way for profitable business intercourse with China and what it can accomplish in the future, they would demand the withdrawal of all legislation looking toward regimented medicine in order that doctors may be left free to pursue their humanitarian plans which have always

been sufficiently fluid to meet the demands of an ever changing world order.

1. Lin Yutang: *The Vigil of a Nation*. The John Day Company. New York. 1944.
2. John Gunther. *Inside Asia*, p. 572. Harper & Brothers, New York and London. 1939.
3. William Henry Welch. *Medicine in the Orient*. Papers and Addresses by William Henry Welch, pp. 178, 180, 181, 182.
4. William Henry Welch. *Opportunities for the Development of Scientific Medicine in China*. Papers and Addresses by William Henry Welch, pp. 170, 173, 174, 175.
5. J. Heng Lui. Editorial. *The Chinese Medical Journal*, Vol. 62, No. 1, Jan.-March, 1944, p. 83.
6. H. C. Hou. *Prevention and Treatment of Common Nutritional Deficiency Diseases*. *The Chinese Medical Journal*, Vol. 62, No. 1, Jan.-March, 1944, p. 32.
7. M. Y. Cheng. *An Investigation of Infant Mortality and Its Cause in Chengtu*. *The Chinese Medical Journal*, Vol. 62, No. 1, Jan.-March, 1944, pp. 48, 49, 50.
8. Donald M. Nelson. *China Can Also Help Us*. *Readers Digest*, Aug. 1945. pp. 66, 68.

The Art of Medicine

If it does nothing else, it occasionally defers their final period; and very generally it renders less rough and painful than would otherwise be the pathway to the tomb; it brings rest if not healing on its wings; it takes some drops of bitterness from the cup which it cannot remove; it smooths the pillow, and it spreads tenderly the couch of our last long sleep.—*Elisha Bartlett. An Inquiry into the Degree of Certainty in Medicine*. 1948.

Pranking Professors

That such practices are not without danger, the possibilities are shown by the following from the pen of Dr. John A. Wyeth.

"I met on the occasion of this visit the renowned Colonel Henry Watterson, editor of the *Courier Journal*, one of the most entertaining and delightful gentlemen it has ever been my good fortune to know. My old teacher, Professor David Yandell, held a reception at his beautiful residence. The crowd soon filled the house and overflowed into a large marquee in the grounds. I had not seen the host since I was graduated in 1869, and several fellow-alumni suggested that we play a trick on the dear old surgeon, who, we might have known, "was not born in the night-time." I took my place in the line filing up to shake hands, and if necessary be introduced, the others in the conspiracy standing near enough to hear our conversation. I did not give him my name as I took his hand, and he said, "You have the advantage of me," to which I replied, "Professor, I am Jim Smith, one of your old pupils from Breathitt County" (said to be the county in Kentucky where every one makes and executes his own law.) But we were hoist on our own petard, for in an instant his handsome face lit up as he put his arms around me and said, loud enough to shock everybody about us: "No, you're not. By God, you're John."

Among the classmates who laughed loudest at the failure of our ruse was Dr. Sam Manly, and I recalled to those present an incident which occurred in 1869, in which he had deservedly met discomfiture. We were calling on the professors to pay our respects before leaving for our homes. The teacher in physiology, one of the most scholarly and dignified members of the faculty, was so very deaf he could not hear without using a trumpet — and this he did not adjust for the ordinary exchange of civilities, such as saying "good-by." As we stood around the sideboard (for this was in Kentucky), glass in hand to drink his health, Sam, intending to excite our mirth and embarrass us at the expense of the dear old deaf professor, and without any thought of disrespect, said, "Here's at you, you bald-headed old vacuum." Before we could even smile at his impertinence, the polite host replied, bowing and touching Sam's glass with his, "The same to you, sir, the same to you."—*John Allan Wyeth. With Sabre and Scalpel*. pp. 389-390. 1924.

CLINICAL PATHOLOGIC CONFERENCE

University of Oklahoma School of Medicine

Presented by the Department of Pathology and Pediatrics.

DRS. BEN NICHOLSON AND HOWARD C. HOPPS

DOCTOR HOPPS: The case for presentation today illustrates a rather uncommon disease which, as in this instance, usually affects children although it may affect adults also. This disease is of interest for several reasons not the least of which concerns its intimate relationships with certain other important diseases from which it is usually differentiated only with considerable difficulty. Doctor Ben Nicholson will present the clinical aspects of this case.

PROTOCOL

Patient: M. J., white male, age 3; admitted 1-6-45; died 1-19-45.

Chief Complaint: Vomiting of blood.

Present Illness: Hematemesis first occurred on July 16, 1944. The patient was taken to a local physician and given transfusions, a special diet and medication which turned the stools black. The patient was never well since that time. In November he suffered a similar episode of hematemesis and again on December 8. Upon this latter attack the local physician was again consulted and the patient's hemoglobin was calculated at 16 per cent. It was stated that the spleen and liver were probably enlarged. Blood transfusions were given. Two days following these the patient had another hemorrhage. He was sent to this hospital for further treatment.

Past and Family History: Non-contributory.

Physical Examination: The patient when first seen seemed acutely ill. He was very pale and pulse was rapid and thready. He was admitted to the hospital immediately and received blood transfusions. Following this the pulse improved as did the color. Mucous membranes and skin showed marked pallor. The chest was barrel-shaped, clear to auscultation and percussion. Blood pressure was 70/50 and pulse 140. The heart appeared normal. The liver extended three finger breadths below the costal margin and the spleen extended to below the crest of the ileum. All superficial lymph nodes were enlarged. Extremities were normal.

Laboratory Data: On admission, urinalysis was essentially negative. Hemoglobin was 4 Gm. and the red blood cell count 1,-

430,000. There were 6,090 white blood cells: 75 polymorphonuclear leukocytes (with 15 stabs) and 25 lymphocytes. On 1-8-45, red blood cells and hemoglobin were essentially the same but an additional note was added: marked anisocytosis; marked poikilocytosis and marked chromophilia. The white cell count was 10,960 with 67 neutrophils (17 stabs), 1 eosinophil, 1 basophil, 30 lymphocytes, and 2 monocytes. The volume index was 1.03. On 1-8-45 bleeding time was one minute, coagulation time 90 seconds. The fragility test was within normal limits. N.P.N. was 17 mg. per cent.

Clinical Course: On admission the patient was given several transfusions of whole blood. The next day he developed marked ascites for which abdominal paracentesis was done. Generalized edema developed and the patient had repeated hemorrhages following almost every blood transfusion. He exhibited an irregular type of fever with several spikes to 104-105 degrees F. In spite of 12 transfusions totaling 1750 cc. the patient continued to become worse and expired on 1-19-45, thirteen days after admission.

DOCTOR NICHOLSON: Since all of you have been furnished with mimeographed copies of this clinical history I shall not bother to recount all of the details but rather shall discuss some of the more pertinent points in order that we may develop a differential diagnosis. The outstanding complaints here was the vomiting of blood. Hematemesis in small children may be the result of:

1. "Hemorrhagic disease of the newborn."
2. Some blood dyscrasia, e.g., purpura, hemophilia or leukemia.
3. Scurvy or malaria, rarely.
4. Banti's disease or cirrhosis of the liver.
5. The swallowing of some corrosive chemical or a foreign body.
6. Most commonly, such a condition results from a vomiting of swallowed blood, e.g., from nose bleed.

It is apparent that some of these possibilities can be readily eliminated from our consideration.

Hemorrhagic disease of the newborn is limited to the first few weeks or months of life. Purpura is apt to be of relatively short

duration and is almost invariably characterized by capillary bleeding in the skin and in the mucous membranes of the mouth and nose with resultant obvious petechial and purpuric areas. Similarly leukemia, if it is of an acute type, as it so frequently is in children, should present purpuric hemorrhages in the skin and mucous membranes; then too the blood picture in this patient does not suggest leukemia. One must not be misled by this point alone however. Leukemia is often very difficult to diagnose in that characteristic changes in the blood may be absent ("aleukemic leukemia") while at the same time there may be a marked or slight hemorrhagic diathesis. On the other hand findings may be principally those suggesting hepatic disease, renal failure, etc. because of an extensive leukemic infiltration in these organs. Hemophilia is incompatible with a normal coagulation time. The possibility of malaria and scurvy may be disposed of because of the lack of any positive evidence.

Banti's disease is a symptom complex characterized by portal hypertension, splenomegaly and anemia. The portal hypertension may, and usually does, result in a marked increase in blood flow through the various venous collateral systems by which blood may be passed from the portal tributaries to the vena cava without going through the liver. From a clinical consideration esophageal varices are one of the most important results of such a process. This is a frequent cause of hematemesis and could well be the basis for that finding in this patient. Ascites, which this patient manifested, is also explainable on the basis of portal hypertension. The splenomegaly and anemia also fits the picture of Banti's syndrome. Unfortunately a variety of other conditions affecting the liver or portal veins may produce a similar picture. Certainly cirrhosis will do it. In this particular case, however, a primary lesion in the liver does not seem likely because first, cirrhosis is quite uncommon at this age, secondly if this represented a case of portal cirrhosis (biliary cirrhosis is not compatible with these findings because of the absence of jaundice etc.) one would expect it to be of longer duration than is suggested by the illness of this child. A third point against this diagnosis is the increased size of the liver. It is true that in the early stages of portal cirrhosis the liver is enlarged but it should be decreased in size by the time ascites, varicosities etc. are manifest. I think it more likely that the cause of the obvious portal hypertension in this case is some extrahepatic lesion which partially obstructed the portal vein. I did not attend this patient nor am I aware of the findings at necropsy. Regarding the treatment that this child received, how-

ever, I can suggest no other therapeutic measures than those which were employed.

CLINICAL DIAGNOSIS

My diagnosis of this patient, based on the clinical evidence, is: portal hypertension of extrahepatic origin with congestive splenomegaly, ascites and bleeding esophageal varicosities with resultant marked anemia. Banti's syndrome cannot, I believe, be ruled out.

ANATOMICAL DIAGNOSIS

DOCTOR HOPPS: Doctor Nicholson's diagnosis is borne out by the finding at post-mortem examination. We were able to determine positively the immediate cause of death as exsanguination from a ruptured esophageal varix. The stomach and upper intestinal tract contained approximately 800 cc. of relatively fresh blood. The course of this hemorrhage was a 5mm. slit-like perforation in a distended esophageal vein just below the esophageal-cardiac junction. There was marked ascites (1500 cc.) and slight bilateral hydrothorax. The liver was slightly larger than normal, but otherwise not remarkable. The spleen was enlarged approximately eight times (e20 Gm.) dark red and quite firm. The heart was dilated about one and a half times normal and was flabby; subsequent microscopic study revealed a marked fatty change of myocardial fibers — the result of severe anemia. The liver and kidneys showed a similar change. The marked anemia was quite apparent also from the pallor of the tissues and the very marked hyperplasia of the bone marrow throughout, representing an ineffective attempt on the part of this patient to replace the blood lost by repeated hemorrhage. These findings are all explained by the portal hypertension and the marked chronic anemia from which the patient suffered. The most important question remains to be answered however; what was the cause of this condition and to what extent can we explain its pathogenesis? I believe that this patient suffered from Banti's syndrome. At the outset I should like to point out that this condition is a symptom complex with probably a variety of causes, hence we should not use the term Banti's disease. As Banti originally described this condition, however, this symptom complex was extended in certain aspects and restricted in certain others so that it became increasingly difficult to know just what characteristics Banti himself considered diagnostic. In spite of many controversial views on the subject, we do have a pretty clear concept today of certain things that Banti's syndrome should include. These are:

- 1) "Primary" splenomegaly.
- 2) Portal hypertension with resultant ascites, esophageal varicosities, etc.
- 3) Anemia.
- 4) Leukopenia.

These last two are not absolutely constant although they are present in a great majority of instances. One of the major difficulties in establishing this diagnosis is that all of the above changes may be secondary to portal cirrhosis and, at the time we have an opportunity to carefully evaluate these patients, cirrhosis may have developed as a secondary manifestation of Banti's syndrome. Under these conditions it is difficult to know whether the splenomegaly was primary or secondary to the cirrhosis. At one time I was skeptical of the existence of Banti's syndrome as an entity. Since that time I have had an opportunity to study eight cases which seem definitely to belong in this category.

In portal cirrhosis, by the time there has developed a definite portal hypertension, we almost invariably find splenomegaly — the result of passive congestion. In such a case, however, the spleen is rarely more than four or five times normal size in contrast to Banti's syndrome as an entity. Since that time I have had an opportunity to study eight cases which seem definitely to belong in this category.

In portal cirrhosis, by the time there has developed a definite portal hypertension, we almost invariably find splenomegaly — the result of passive congestion. In such a case, however, the spleen is rarely more than four or five times normal size in contrast to Banti's syndrome in which it is usually increased in weight eight to ten times. Often too, the morphologic changes in the spleen are definitely older than those in the liver. A peculiar type of fibrosis, so-called fibroadeneia, and a certain pigmentary change in the Malpighian corpuscles has been considered pathognomonic by some. This is not so however; marked congestion from any cause may produce similar changes. In several of the cases which I have studied there has been a chronic phlebitis of splenic veins. This, I believe, is one cause of Banti's syndrome and explains, in some cases, the subsequent involvement of the liver by cirrhosis — the phlebitis migrates gradually through the splenic and portal veins ultimately involving the intrahepatic veins to result in cirrhosis. It would be in this type of case particularly where early splenectomy would be curative in that the source of the slowly migrating phlebitis would be eliminated. In this particular case, however, careful search revealed no phlebitis in the veins of the spleen or liver, similarly the splenic and portal

veins appeared normal. The pancreatoduodenal and several mesenteric veins did however present a chronic low-grade thrombophlebitis. The spleen, histologically, presented the peculiar fibrosis and pericorpuscular hemorrhages characteristic of Banti's syndrome. This with the marked splenomegaly of 320 gms. (the normal size for a three year old child is 40 gm.) and the absence of any hepatic lesions or changes in the portal vein point with considerable certainty to the diagnosis of Banti's syndrome.

DISCUSSION

DOCTOR HOPPS: According to the history, this child developed the ascites rather suddenly following several transfusions. Were the transfusions responsible for this, Dr. Nicholson?

DOCTOR NICHOLSON: In retrospect, I believe that this child had a sub-clinical ascites at the time of first examination. It may well have been that the rather rapid infusion of whole blood which was necessary to combat the effects of severe hemorrhage in this child did lead to a temporary increase in portal hypertension and to the sudden accumulation of more fluid so that the ascites became clinically evident.

DOCTOR HOPPS: Do you think that splenectomy might have helped the child?

DOCTOR NICHOLSON: At the time this child was admitted here I believe that splenectomy was out of the question. At no time was this boy in a condition to have tolerated a major operation of this type. I believe it unlikely that splenectomy would have helped anyway. It might have helped earlier — I do not know.

DOCTOR HOPPS: Considering the cause of Banti's syndrome in this instance, there are three major hypotheses as to the cause of Banti's Syndrome. Each of these is primarily concerned with an explanation for the portal hypertension which has been proved to exist by direct measurements of portal venous pressure at operation in a considerable number of human cases.

It is thought by some that Banti's syndrome may result from any process which produces hypertension in the splenic vein and that in some instances this condition may be the result of portal cirrhosis. According to this hypotheses if cirrhosis does develop as a part of the picture, it is the initiating cause and thus splenectomy will not protect the patient from developing cirrhosis. It is considered that the splenomegaly is secondary to marked congestion from any cause. The second hypothesis I have mentioned before — that of a low grade phlebitis with progressive sclerosis of the splenic and portal veins. The cause of such a phlebitis is

unknown. A third possibility which has been but recently advanced is that the underlying cause of portal hypertension is an increased blood flow through the splenic arteries. It is thought that this excessive inflow of blood overloads the portal system and that congestion, ascites, varicosities, etc. result. This is a rather attractive hypothesis and would best fit the findings in this case. However, it does not seem reasonable to me that enough blood could flow through the malpighian arterioles to cause a marked portal hypertension. I'm sorry that I can give no definite answer as regards this case.

DOCTOR NICHOLSON: What is the explanation of the generalized edema in this case?

DOCTOR HOPPS: This child had suffered repeated hemorrhages and, in addition, had had a rather restricted diet. Such a situation is quite analagous to the plasma phoresis experiments of Leiter, Whipple and others by which means hypoproteemia was produced in dogs with resultant nutritional edema. The dogs had an advantage as a matter of fact—their erythrocytes were re-infused. I believe that this child had nutritional edema and that that, in addition to producing a generalized edema, probably contributed also to the ascites.

Of this group also was my fellow-student at college and soon thereafter my teacher in advanced pathology, William H. Welch, who transcendent genius for research has made him *facile princeps* among American pathologists. When my increasing labors pressed me so far time that I could no longer work in his laboratory, I equipped my own office, and two evenings of each week this enthusiastic and generous friend came to help me in the efforts to keep in touch with the latest developments in the science in which he was master. . . .

Soon after my return from Europe in 1878 the frightful epidemic of yellow fever broke out in Memphis, causing panic and flight for all who could escape, and anxiety, suffering, or death for those who could not run away, or who, like the doctors of that city, remained at their posts. Thinking it our duty to offer our services to our own afflicted people, my old Confederate comrade, Dr. William M. Polk and I telegraphed to Dr. John H. Erskine that we would go to Memphis if he thought we could be made useful. To our great relief, Dr. Erskine, who had been a medical director in the Army of Tennessee, replied: "Don't come. You would be down with fever in two weeks, and would add to our anxieties." He died of the fever in this epidemic.—*John Allan Wyeth. With Sabre and Scalpel. p. 379-380. 1924.*

Speaking of Small-Pox

In this connection, also, I may, more appropriately than anywhere else, allude to the almost entire extirpation of small-pox, through the agency of vaccination. I could not have found nor chosen a more fitting conclusion to this long and brilliant catalogue of the achievements of medical science and medical art; it is the richest gift that our science has ever laid on the altar of humanity; let it be the crowning rose of the garland we have woven for the august and godlike forehead of the genius of our art. In the general exemption from the ravages of small-pox, which we have now enjoyed for nearly half a century, we are likely to forget, and to under-estimate the dread, the suffering, and the mortality that formerly followed in its train.—*Elisha Bartlett. An Inquiry into the Degree of Certainty in Medicine. 1948.*

Fitful Blaze

● Unaccountable pain and tension . . . vasomotor disturbances . . . irregularity . . . mental depression—all contribute to the familiar menopausal picture. *A picture that flickers—like firelight on a wall—interrupting many a woman's life program at its busiest.*

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THE PRESIDENT'S PAGE

The greatest victory of all times came to our great United States since our last month's issue and we are truly thankful for that victory. We must all realize that with Victory there are added responsibilities that have never confronted us before and our acceptance of this responsibility must not be weighed in balance and found wanting. Victory for an individual, community, State, Nation or Nations too many times disturbs their equilibrium to the point of degeneration. It takes more than a majority vote or a campaign promise to provide adequate medical care but a slogan that is worthy of detailed analysis.

Our State Society is meeting with success in its educational program, yet it is the responsibility of every member of every department and every committee assigned to its task to round out success and attain the goal that is capable of being reached only through sacrifice, application, the denial of personal pleasures and the sincere devotion to the pledge we assumed when we cast our lot to administer to the human ills of suffering humanity.

After our summer's relaxation, this month, we again resume our program and ask that every member of the Speakers Bureau give serious consideration to the problems that they are to discuss. We also ask that the committees of the State Association get their program for the year well in hand for a meeting that will be called within the next two or three weeks wherein we will have a council of peace and arrange and adjust our efforts for the most worthwhile service that can possibly be rendered to the people of our State.



President.

FIRST IN A SERIES OF CHALLENGES TO MEDICINE'S
Achievements For Tomorrow

● RHEUMATIC FEVER is one of the major, yet least understood, health problems in the United States today. It is a large factor in producing heart disease, the leading cause of deaths—394,915 in 1942*.

The cause of rheumatic fever and the mode of its transmission are not known. Treatment, therefore, has been directed, in part, toward efforts to control the disease by keeping the patient at rest. Sulfonamides and salicylates are used to help prevent subsequent attacks, the patient shielded from exposure, and fed a nutritious diet. Physicians are constantly helping in the solution of this problem by reporting their clinical observations. The need is to determine the cause and discover a drug, vaccine or serum to prevent or combat it. Until that occurs, the laity should be educated to watch for the symptoms, especially in children, and to secure prompt medical attention.

To help in this education we have prepared a pamphlet—"Watch Your Health"—which gives facts, simply stated, about this and six other serious diseases. Copies for distribution to your patients available on request.

*U. S. Summary of Vital Statistics, 1942.

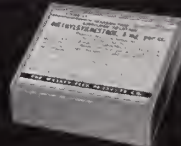
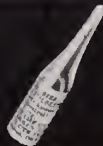
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EDITORIALS

ATTENTION

Officers and Members of County Medical Societies: The following appeal from Captain Oglesbee should not go unheeded. Every County and District Medical Society should take these suggestions under advisement and initiate plans for their execution when the opportune time arrives.

No doubt President Tisdal and the Council of the State Medical Association would consider this service within the scope of our present educational program and provide suitable instructors under the direction of the Postgraduate Committee with Mr. Kibler in charge.

To give this editorial comment a turn which should touch the heart of every civilian doctor on the home front, the following paragraph is quoted from Captain Oglesbee's letter addressed to the Editor:

"I am enclosing a suggestion for using each County Medical Society as a professional rehabilitation center for returned physicians who have sacrificed their home life, their practices, and any possible professional advancement because of the war.

"Many of these doctors have performed monotonous tasks which require little or no medical knowledge or skill. For each "Army

Surgeon" as portrayed by the movies, magazines, etc., there are many doing administrative work. For each medical officer assigned to army hospitals there are many who devote all of their time to sanitary inspections and "sick call"; duties that our medical student sophomores could perform with great skill. At the slightest indication of actual illness in a patient, the field medical officer sends him off to a hospital, and so far as he is concerned, the case is closed.

"This situation is not improved greatly by combat experience! The duties of battalion surgeons and collecting company surgeons consist mainly of applying emergency splints and dressings and administering plasma. The clearing company surgeons frequently have little to add to the treatment but the administration of tetanus toxoid and more plasma. In severely wounded cases each hospital in the subsequent chain of evacuation performs one phase of the surgical treatment. The final operation is often performed in the United States.

"This system of treatment is necessary in war, but it is poor training for civilian practice. No surgeon sees the whole picture. The responsibility for the condition we find ourselves in lies entirely with the Axis Powers.

Most of the correction of this condition is going to be left up to the medical profession.

"I am familiar with the general situation of which I write. The basis for my opinion is experience gained in several training camps in the United States, and in the Sicilian, Naples-Foggia, and Rome-Arno campaigns while serving with the Forty-Fifth Division, and in my present assignment with the Eastern Defense Command."

A LOUSY SITUATION

In World War I it was thought the progress in medical science would prevent major epidemics. On the Western front this hope was realized, but on the Eastern front, typhus soon reared its ugly form and marched ahead of the most astute strategists.

In spite of the existing delousing technique then available, ultimately Russia was engulfed in a profound epidemic. Typhus was no stranger to the Russian people. They were accustomed to more than 80,000 registered cases annually with a mortality varying from 20 to 60 per cent, always rising with war and famine.

According to Sigerist¹ twenty to thirty million cases developed in Russia during the four years between 1918 and 1922 with a mortality of 10 per cent. As early as 1919 Lenin said, "Either socialism will defeat the louse, or the louse will defeat socialism." Lenin was reasoning from false premises. Medicine has defeated the louse. In this country we must see that socialism does not defeat medicine.

1. Sigerist, Henry E.: *Civilization and Disease*. Cornell University Press. Ithica, New York. 1943.

HATS OFF

We make our bow to lay magazines in grateful recognition for a genuine service to their readers through recent articles dealing sanely with the now popular question of Medical Service.

Colliers¹ under the title "German Doctors Under Naziism" says:

"Shortly after V-E Day, Colonel Edward D. Churchill, Allied Mediterranean forces' surgical consultant, toured six German military hospital areas and reported his findings to American correspondents.

"... His over-all conclusion after inspecting six German hospital areas was that German handling of wounded was about 20 years behind the American procedure.

"The lesson in the German experience seems clear enough. It is that there is no substitute for a free, bold and inquisitive medical profession, or for generously financed and expertly staffed medical research, carried on year in and year out. It is devoutly to be hoped that the lesson of the German medical collapse will not be lost on us."

In the Saturday Evening Post, an article by Dr. Mary B. Spahr² "A Doctor Looks at State Medicine" presents some illuminating facts as may be observed from the following brief quotations.

In the first paragraph we find: "Discussions of the Murray-Wagner-Dingell Bill ought to clarify the issues raised by socialized medicine. Instead, they are fogged up in a haze of prejudice and special pleading. . . . This experience with relief medicine is overlooked by the framers of the Wagner Bill. Most people assume that the Bill makes generous provision for the indigent. Careful perusal reveals exception after exception which relieves the Federal insurance funds of the most expensive cases. For example, the Bill does not cover tuberculosis, mental disease or the infirmities of old age. It does not even cover the indigent. Carefully studied, the Wagner Bill is found to be limited to the protection of medium-sized incomes from middle-sized diseases.

"... We Americans have had privacy for so long that we forget the value of the freedom from intrusion guaranteed in our Bill of Rights. Whether or not Federal medicine sends its workers into our homes to investigate our need for medical care or to urge us to follow medical advice, we shall lose our privacy. A doctor not bound to secrecy will be an intruder. Now the doctor is welcomed as a member of the family. If he does a bad job, we know he will not answer criticism against himself by citing our failings. But imagine the things he could say if he is accused of neglect of duty before an appeal body, as he can be under the Wagner Bill.

"... Financial returns are secondary to the satisfaction of doing good work. We doctors will favor no plan until we are convinced that it will advance the well-being of our patients. There are many alternatives to the Wagner Bill which would confer all the benefits possible without paralyzing medical practice."

In Reader's Digest, Paul D. Kruif³ in discussing "Home Town Medicine" says:

"Shall we support the plan for nation-wide compulsory health insurance, Government socialized medicine? The medical socializers propose a tax of \$3,000,000,000 yearly, to be poured into a central bureau in Washington and then doled out to the country's doctors. That vast and sprawling project would inevitably result in an unwieldy bureaucracy, rendering inefficient medical service.

"... But medical science involves more than having a baby or an operation. And our doctors have already developed a way, not bureaucratic, strictly home-town, by which complete medical care can be brought within reach of the average citizen."

No doubt similar articles appearing in other current periodicals not coming to our attention are equally entitled to notice.

1. Colliers, Friday, July 27, 1945.
2. Spahr, Mary B., A Doctor Looks At State Medicine. The Saturday Evening Post. July 21, 1945.
3. De Kruif, Paul: Home Town Medicine. The Reader's Digest, July, 1945.

CERTAINTY AND UNCERTAINTY IN MEDICINE CONFUSED BY LAY REPORTING

In the June 14 issue of the New England Journal of Medicine, Bakwin¹ discusses what he considers "current pediatric errors" and undertakes the task of explaining why they persist. After briefly discussing unwarranted theories and practices long since discarded, he devotes much space to remaining equally erroneous and harmful practice now in vogue. His criticisms are directed against the increasing percentage of hospital deliveries; 2) the unwarranted or indiscriminate removal of tonsils; 3) the too frequent incision of the eardrum; 4) faulty hospital care for infants and children and inadequate attention to emotional factors; 5) errors in the psychological management of the child; 6) unwarranted use of vitamin compounds; 7) errors in pediatric education. On the whole, the Bakwin article is sound and this criticism is most timely for doctors and patients alike if properly presented for lay consumption. As it appeared in the New England Medical Journal, the article was written for doctors and not for laymen. Unfortunately, "Time"² in characteristic fashion, dishes it out to the lay reader in isolated chunks under the sensational title, "Doctor, Spare the Scalpel," thus making it even more misleading for mothers and fathers.

After making use of an indictment against medicine in Bakwin's quotation from Proust,³ "For medicine being a compendium of the successive and contradictory mistakes of medical practitioners, when we summon the wisest of them to our aid, the chances are that we may be relying on a scientific truth the error of which will be recognized in a few years' time." The "Time" writer finds it convenient to ignore the latter half of the quotation which justifies the zigzag course of medical science in pursuit of truth and which would tend to comfort the layman who is being confused by the fact that throughout the discussion the most important truths are being withheld. To complete the quotation and reveal what Proust really accepted as the truth, we add the omitted portion and regret that "Time" did not have the wisdom and the fairness to give the full text to the lay reader. "So that to believe in medicine would be the height of folly, if not to believe in it were not greater folly still, for from this mass of errors there have emerged in the course of

time many truths." Also "Time" might have let the people know that Marcel Proust was a French novelist and not a physician and much more skilled in literary phraseology than medical knowledge. The medical editor might have called attention to the fact that much of our progress in medicine has been achieved since the death of the novelist Marcel Proust (1871-1922).

Unfortunately, Bakwin³ did not know "Time" would grab at the opportunity for a sensational unilateral discussion with what might be interpreted as willful omissions of compensatory truths which should reveal the saving of life in infancy, the fostering of health in childhood and adolescence and the better physical development at maturity all resulting from the rapid progress of medical science always through the process of accepting established truths and discarding fallacies. If Bakwin had been writing for the lay reader he would have admitted that many pediatricians are seeing eye to eye with him and that in spite of the defects in the practice of pediatrics the public should be well informed with reference to scientific progress in this field which has so materially advanced human welfare. When will the medical profession recognize the freedom of the press and do something about lay medical publicity.

The opening paragraph from Bartlett's "Certainty in Medicine"⁴ published approximately 100 years ago, shows how tardy we are. "I am stating only what everybody knows to be true, when I say that the general confidence which has heretofore existed in the science and art of medicine, as this science has been studied, and as this art has been practiced, has within the last few years been violently shaken and disturbed, and is now greatly lessened and impaired. The hold which medicine has so long had upon the popular mind is loosened; there is a wide-spread skepticism as to its power of curing diseases, and men are everywhere to be found who deny its pretensions as a science, and reject the benefits and blessings which it proffers them as an art."

Robert W. Haxall⁵ made the following significant statement in 1936. "The multiform mutations which have attached to medical practice, even since it has justly assumed for itself the appellation of a science, have no doubt contributed in a great measure to lessen the confidence of many an enlightened mind in its utility and benefit. When we consider, however, the exceeding difficulty which attends our examination into the true and infallible causes of disease, and the just and rightful appreciation of remedial agents; and when we reflect upon the absurd and even yet unconquered aversion to post mortem examinations, we should cease to won-

der at the various changes which mere theoretical opinion has hitherto advanced."

Finally, we take courage in the eloquence of Bartlett's⁶ closing remarks: "No, there is no danger. The work of two thousand years is not to be demolished by the noisy clamor of a few penny trumpets. As certainly as there is truth in the foregoing inquiry, will the present feeling of distrust towards our science and our art pass away. The ancient confidence will be restored; the old love will come back again, truer and deeper for the transient and passing estrangement. The constellations themselves — Orion and the Pleiades — are sometimes apparently blotched out from the heavens, by the gorgeous glare of rockets and other artificial fireworks, kindled with sulphurous and nitrous compounds; but, courage! my friends, and a little patience, — the show will soon be over; the parti-colored flame that would rival and eclipse the planets is even now dying away; all that will remain of the blazing illumination will be some noisome gases in the atmosphere, and a few burnt out sticks on the ground; but lo! still looking down upon us, with their dear old smile of affectionate recognition, from their blue depths in the firmament, undimmed in their brightness and unchangeable in their beauty, the everlasting stars."

1. Marcel Proust. Harry Bakwin. *Pseudodoxia Pediatrca*. The New England Journal of Medicine. Vol. 232, No. 24, p. 697. June 14, 1945.

2. Time. Doctor, Spare the Scalpel. Vol. XLVI, No. 2, p. 46. July 9, 1945.

3. Marcel Proust. Harry Bakwin. *Pseudodoxia Pediatrca*. The New England Journal of Medicine. Vol. 232, No. 24, p. 697. June 14, 1945.

4. Elisha Bartlett. *An Inquiry into the Degree of Certainty in Medicine*, p. 9. Lea and Blanchard, Philadelphia. 1848.

5. Robert W. Haxall. *Library of Practical Medicine*, p. 83. Perkins & Marvin, Boston. 1936.

6. Elisha Bartlett. *An Inquiry into the Degree of Certainty in Medicine*, p. 84. Lea and Blanchard, Philadelphia. 1848.

COCKTAILS AND COWPOX

In a delightful vein, Reginald Fitz¹ makes medical history interesting as he carries us toward the introduction of vaccination into America by Benjamin Waterhouse. This feat is accomplished under the interesting title, "Conviviality and Its Possible Usefulness in Advancing Medical Knowledge."

Dr. Fitz' theme is well illustrated in the following paragraph:

"As an example of what I have in mind, it is my contention that if King George the Third, King of England, had not happened to have had a son born at Buckingham House in London on the second of November, 1767, Dr. Benjamin Waterhouse of Cambridge could not have dined with him; if it had not been for this dinner Doctor Waterhouse might have been unable to introduce vaccination into America as promptly as he did, and lacking this new procedure, smallpox might have been an even more serious

pest in this country for a longer time than it was."

It is pointed out that Edward Augustus, Duke of Kent, the father of Queen Victoria, was at Montmorency Falls in command of the Seventh Royal Fusiliers. In 1794 he was ordered to the French West Indies. On the way, the dashing young Duke stopped in Boston where the influence of position and social charm opened the way for a gay interlude. After responding to various invitations, with obvious popularity, he was entertained by the British Consul, Thomas McDonough at a small dinner to which President Willard, Mr. John Lowell of the Harvard Corporation and Doctor Waterhouse were invited.

After a lively intellectual discussion of current issues, the evening being well spent, Willard and Lowell departed. Strange to say, the staid Waterhouse who ordinarily would have accompanied the Harvard intellectuals had passed under the charm of the Royal Duke and McDonough's drinks. The conversation and good fellowship were running high under the influence of port and brandy and Waterhouse exhibited an unaccustomed warmth, revealing intimate desires and ambitions. He told of the loss of the Harvard College Library by fire and the need of books, especially British books, which were duty free. The Duke, though disclaiming scholarship, was responsive and tentatively proffered his assistance. As the night wore on, the bonds of friendship were welded with laughter and song. Not only did this episode elevate Dr. Waterhouse in local social circles, but the Duke and his aides, being impressed with his good fellowship and fine sense of humor, sang his praises abroad and in time he was not without fame even in England.

Several years later, 1880, when he opened negotiations in England for some of Jeuners' virus, the arrangements were facilitated by the reputation achieved through the conviviality of the McDonough dinner party. The virus was forthcoming and the story of the introduction of vaccination by Dr. Waterhouse is well known. But often its influence upon public health is overlooked. It has been said that vaccination added three years to the life of every individual for all time.

The Language of Disease

To arrive at the ability to judge of the identity of internal alterations and conditions through their external signs, and thus to obtain the data for the application of former experience, is the end of the science of symptomatology. It is, in short, the learning to understand the obscure language of disease, without rightly interpreting which, its calls cannot be attended and supplied.—*Library of Practical Medicine. Massachusetts Medical Society. Vol. VII, p. 14. 1936.*

ASSOCIATION ACTIVITIES

INTENSIVE COURSES TO BE OFFERED AT TULANE

Dr. H. W. Kostmayer, Dean and Director of the Department of Graduate Medicine, Tulane University, New Orleans, has stated that short intensive courses of a week's duration will be available at Tulane as follows:

Internal Medicine.....October 15-20, 1945

Traumatic and Emergency

SurgeryNovember 5-10, 1945

PediatricsNovember 10-14, 1945

Obstetrics & GynecologyJanuary 14-18, 1946

The Commonwealth Fund has available a limited number of fellowships covering transportation, for the round trip to New Orleans, tuition and a stipend of \$50.00 for each of these courses. Physicians interested in being considered for a scholarship to cover one or more of these courses, should make personal application to the Division of Public Health of the Fund.

As in the past, applicants may be required to submit to a personal interview with a member of the Fund's staff at some central point within the States, and preference will be given, in making awards, to physicians who are now, or expect to be, located for practice in communities of less than twenty-five thousand.

FLASH!

OKLAHOMA CITY CLINICAL SOCIETY TO HOLD ANNUAL MEETING

Through the new ruling of the Office of Defense Transportation, permission has been granted that the Oklahoma City Clinical Society may hold its annual fall meeting.

The meeting will be held at the Biltmore Hotel in Oklahoma City, November 26, 27, 28, and 29.

WELL ATTENDED MEDICAL AND PUBLIC MEETINGS HELD IN DUNCAN

On June 25, District No. 5 held a District Councilor meeting in Duncan under the supervision of Dr. J. L. Patterson, Councilor. Dr. Patterson also arranged a public meeting in the high school auditorium with the cooperation of the Chamber of Commerce of Duncan.

The program for both meetings was furnished by the State Medical Association and was in line with the program that is being carried all over the state.

At 7:30 P.M., thirty-two physicians from Duncan and surrounding towns assembled in the Chamber of Commerce rooms. Dr. V. C. Tisdal, Elk City, President of the State Association, opened the meeting by explaining the different phases of the Four-Point Program and the desire of the Association to help the members and the County Societies.

Mr. N. D. Helland, Blue Cross representative from Tulsa, next spoke on the Blue Cross Hospital Plan and the Prepaid Medical and Surgical Plan. He explained to those present how these plans differ from the commercial insurance plans.

Many of the members asked questions concerning the plans and an informal discussion followed Mr. Helland's talk.

Dr. C. R. Rountree, Oklahoma City next spoke on the responsibility of the Association to the County Societies. He explained the membership of the A.M.A. and the benefits to the members.

The next speaker was Dr. Wendell Long, Oklahoma City, who spoke for the Cancer Committee. Dr. Long gave a very interesting history of the American Cancer So-

ciety and told of the recent Cancer Drive. He explained how, through the raising of funds, more tumor clinics would be available, also more thorough aid to the incurable. Above all, Dr. Long stated, funds would be available for more adequate educational facilities and for research.

Dr. Grady Mathews, Oklahoma City, spoke for the State Health Department, stressing the closer cooperation between preventive medicine and curative medicine.

Mr. Paul Fesler, Oklahoma City, was called upon to explain the recent health bills that were passed. He explained the importance of these bills to the medical profession and outlined the legislative progress made during the recent years. Mr. Fesler then explained the Hill Burton Bill and urged each member to advise his congressman and representative that the medical profession approve the Bill. He also discussed the new Wagner Bill, S. 1050, pointing out the pitfalls.

Dr. Ed N. Smith, Oklahoma City, was called upon to close the meeting with his chosen topic "Maternity Mortality." Dr. Smith gave a very interesting discussion about the appalling number of deaths from toxemia and abortion, stressing the fact that these causes of death were entirely preventable through education to the public.

The public meeting, with an attendance of twenty-nine, was successfully conducted, having the same speakers as the medical meeting. Great interest was manifested and it is felt that the urgent message that was carried to the people was gratefully received.

GROUP OF THREE MEETINGS HELD FOR DISTRICT NO. 10

John A. Haynie, M.D., Durant, Councilor for District No. 10, arranged a group of two meetings for the membership of the District and one meeting for the students of Southeastern State College of Durant.

Durant Meeting

On June 26, Dr. John Haynie and Dr. W. K. Haynie, entertained thirty-five members of District 10 and the speakers of the program with a dinner at the White House Cafe in Durant. Drs. Haynie furnished the excellent dinner which consisted of squirrel, fish and chicken.

The program for the Durant meeting was furnished by the State Association and included as speakers, Dr. V. C. Tisdal, Dr. Tom Lowry, Dr. J. T. Bell, Dr. Ed N. Smith, Dr. Richard M. Burke, Dr. Joseph Kelso, Dr. L. C. Kuyrkendall, Mr. N. D. Helland, Dr. C. R. Rountree, Mr. Paul Fesler and Dr. A. S. Risser. The program was opened by Dr. John Haynie who extended greetings and welcome to the members, speakers and guests. He gave a brief history of the medical profession in that section of the state, outlining the great strides that had been made in public health and in organized medicine. Dr. Haynie then introduced Dr. Tisdal and turned the program over to him.

Dr. Tisdal first introduced Dr. J. S. Fulton, retired Councilor, who said a few words. Dr. Tisdal explained the Four-Point Program and stated that the doctors in the various districts should endeavor to know more about the State Association. The Speakers Bureau was then discussed and the members were urged to call on the Association for a speaker for any meeting, either medical or lay, that was to be held in his community.

Dr. Tom Lowry, Dean of the Medical School, was the first speaker on the program. He acknowledged the presence of Representative Bill Parrish and expressed the gratitude of the Association for the legislation recently passed. Dr. Lowry told of the courses to be offered in

the Medical School, i.e., the training courses for hospital staff members, nurses, laboratory technicians and x-ray technicians. He stated that when the men were released from the service it was going to be a big responsibility to see that they received the courses needed and wanted, and further stated that the University of Oklahoma School of Medicine would make every effort to best fill the responsibility.

Dr. J. T. Bell, Oklahoma City, State Health Department, spoke on preventive medicine, and the facilities offered by the Department for caring for the children from birth to the grave.

Speaking for the State Tuberculosis Association, Dr. Richard M. Burke, Oklahoma City, stated that the tuberculosis program has been stepped up considerably as a result of the war by the use of the portable x-ray units. He stated that the individual physician is the key man in the tuberculosis picture and that it is through him that the cases are uncovered and the contacts discovered.

Dr. Joseph Kelso, Oklahoma City, next spoke for the Cancer Committee. He briefly outlined the history of the American Cancer Society and told of the recent drive for funds. Dr. Kelso asked that the members offer suggestions as to the spending of the funds for the control of cancer. One suggestion that had been offered, said Dr. Kelso, was that a mobile diagnostic unit be established for the purpose of touring the state, the unit to be named by three physicians and a secretary.

The next speaker was Dr. Ed N. Smith, Oklahoma City, who spoke on Maternity Mortality. Dr. Smith cited the various causes of death and explained how the majority of them were preventable. He told of the questionnaires that had been sent to physicians over the state in an effort to determine the exact causes of death and to better enable the doctors to find a means of prevention.

The Wagner Bill was next discussed by Dr. L. C. Kuyrkendall of McAlester. Dr. Kuyrkendall explained the Bill in detail and urged the physicians to continue their efforts in fighting regimented medicine as offered in the Bill. The new Wagner Bill, S. 1050, reduces the taxation from 6 per cent to 4 per cent in an effort to sway the public.

Mr. N. D. Helland, Tulsa, Blue Cross Representative, next told the members how the Blue Cross was set up to combat the Wagner Bill and any form of regimented medicine by taking care of the public economically.

Dr. C. R. Rountree, Oklahoma City, next read the Health Bills that were passed in the last Legislature and spoke briefly of the new State Board of Health.

The closing speech of the evening was delivered by Dr. A. S. Risser of Blackwell. Dr. Risser, in speaking of the Wagner Bill, reminded the members that there was nothing in the Bill that provided that the Surgeon General who would be in charge of the Medical Bureau be a medical man. Dr. Risser said, "I know of no man better qualified to educate the public than the general

practitioner. Please do not be too busy in your office to stop and explain the importance of the Bill and its pitfalls. If we will educate the layman and talk to our patients and tell them what it means, they will talk to their congressmen and representatives."

At the close of the meeting a motion was made by Dr. L. C. Kuyrkendall of McAlester, seconded by Dr. A. S. Risser of Blackwell, offering appreciation and thanks to Dr. John Haynie and Dr. W. K. Haynie for the meeting and the dinner.

Southeastern State College Meeting

Dr. John Haynie, Councilor for District 10 arranged a meeting to be held in the auditorium of Southeastern State College at Durant, for the students, the meeting to be called at 10:00 A.M., June 27.

The assembly was called to order by President T. T. Montgomery who expressed appreciation to the doctors to come to Durant to speak to the students. Dr. John Haynie delivered the devotional.

The meeting was turned over to Dr. V. C. Tisdal, Elk City who introduced the following who were present and were on the stage of the auditorium: Mr. Paul Fesler, Executive Secretary of the State Association; Mr. N. D. Helland, Tulsa, Blue Cross Representative; Dr. A. S. Risser, Blackwell; Dr. L. C. Kuyrkendall, McAlester; Dr. C. R. Rountree, Oklahoma City; Dr. John Haynie, Durant; Dr. Joseph Kelso, Oklahoma City; Dr. Tom Lowry, Oklahoma City, Dean of the Medical School. Dr. Tisdal explained the Four Point Program of the Association and said, "We feel that you are the people who can and will assume the responsibility of carrying public health to the different parts of the State."

Dr. Tom Lowry was called upon and said, in part, "The School of Medicine of the University of Oklahoma is for the medical education of Oklahoma. The future health will depend on the number and quality of graduates from the School. It is the duty of the School to train doctors to treat and to educate the people. Four million men have been rejected from military service because of lack of education — two and a half million are suffering from diseases that can be cured if people are educated. The Oklahoma State Medical Association has a program of education for the people of Oklahoma whereby these people can disseminate the information on adequate medical and hospital care."

Dr. C. R. Rountree, Oklahoma City, the next speaker, said, in part: "The best thing that an individual state or nation can have is good health. For many years the American Medical Association has advanced as one of its prime tenets 'the best medical care to the greatest number of people.' With that in mind we shall continue to fight and continue to work until adequate medical care is within the reach of every individual. . . . During this past emergency we have had some 625 doctors in the Armed Forces. They are coming back to take their places in order to administer to civilian needs. . . . Until the last legislature we were one of three states in the

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Union without a State Board of Health — this Board has now been created and is being set up to serve the people of the State of Oklahoma.”

At this point Dr. Rountree read a complete list of the Bills passed in the last Legislature. In closing he said, “There has been no other state in the union with such a pretentious, far-reaching public health program.”

Dr. Joseph Kelso, Oklahoma City, member of the Cancer Committee, next spoke on the subject of Cancer. “We must educate you so that you will come in early enough. Do you realize that 25 of you will die of cancer? We are just finishing a five million dollar campaign for funds to be spent for the education of the people, research, and service for the incurable. Oklahoma’s share of the funds will be \$75,000.00, which will be spent for the detection and treatment of cancer. It has been suggested that a mobile unit be established to tour the state to give this detection service to the people. . . . We are interested in giving you facts as you are needed to take them into the schools. It is through you, as teachers, that we will establish a greater part of our educational program.”

Dr. A. S. Risser, Blackwell, the next speaker, chose as his theme “You can lead a horse to water but you can’t make him drink.” Dr. Risser said, in part: “There is no line of endeavor in which the advance has been so rapid for the betterment of mankind as that of medicine. You may wonder why the doctors come out over the state. Six hundred thousand people a year die of preventable diseases. . . . the doctor can’t help you if you don’t come to him. As I have said before, you can lead a horse to water but you can’t make him drink — and that means that we can try to carry the message to the people but it is up to them from that time on. We tell you to treasure your health. . . . it is a free country with a free people who do as they please but we urge you to consult your doctor in time so that he may help you.”

Dr. Risser then explained the Wagner Bill and said, “Will the American people be led astray through lack of knowledge of these things? There are two ways that diseases can be prevented; 1) education of the men and women; 2) regimentation and dictatorship. . . . which do you want? You are the men and women who must learn these things because — the horse has to be educated to learn to drink.”

Hugo Meeting

At 7:30 P.M., June 27, the members of District 10 who had not attended the meeting at Durant the evening before, assembled for dinner at the First Methodist Church in Hugo. There were 35 members and guests present, two of the distinguished guests being Senator Bayless Irby and Representative Hal Welch. The program presented was the same as presented at Durant and was enthusiastically received.

Book Reviews

ESSENTIALS OF BODY MECHANICS IN HEALTH AND DISEASE. Goldthwait, Brown, Swain, Kuhns. J. B. Lippincott Company. Philadelphia. 1945. Price \$5.00, 302 pages.

In the preface the authors are of the opinion that many of the rejections brought about by Selective Service could be avoided if faulty body mechanics had received proper attention in childhood. They also stress the importance of proper training to those individuals with body deformities and defects. They especially stress the anatomic features of the body as a whole and pay particular attention to body sag, visceral damage, and disturbance of the special systems. They then divide the patients into types and show susceptibility to disease found in the slender and stocky types. By means of illustrated cases and an outline of the exercise, the authors demonstrate improvement and correction to the circulatory system and the relationship between angina pectoris and postural emphysema related to obesity. The abdominal viscera are discussed individually. It is pointed out

that interference in the function of these various organs, due to improper posture, is directly related to future disease.

Chronic arthritis admittedly follows a prescribed course under any type of therapy, but occasionally a great deal of benefit is given to a few cases which merits a trial if it will give relief to their discomfort.

A new chapter has been added on feet with illustrations and comprehensive study and exercises designed to improve the disabilities.

On the whole, this book contains many worthwhile and instructive suggestions which can be used by all doctors.—P. K. Graening, M.D.

CONSTITUTION AND DISEASE. Applied Constitutional Pathology. Second Edition. Revised and Enlarged. Julius Bauer, M.D., Grune and Stratton, New York. 1945.

In the March, 1943 issue of the Journal, the reader will find a review of the first Edition of Julius Bauer’s valuable little book under the above title. The publication of a Second Edition in less than two years is an indication of its value to the medical profession and suggests a growing interest in “constitution” as related to disease. In other words, the importance of looking upon the individual patient as a composite whole.

The following paragraphs from the Preface to the Second Edition are quoted with the hope that those who read this review may be prompted to read the book.

“Reviews and comment from professional organs and among individual readers have given proof of almost universally favorable reception of the book. An editorial given to it in the British Medical Journal, and the publication of a Portuguese translation in Rio de Janeiro in 1943 and of a Spanish translation in Buenos Aires in the same year, would indicate that the need for a book of this type is likewise perceived in other countries of both hemispheres.

“For the general practitioner, the discussion may give substance to the idea expressed in the aphorism of an English reviewer: ‘In clinical medicine the laboratory is a good servant but a bad master.’—Lewis J. Moorman, M.D.

Sims and Wyeth

When two years later in New York Dr. Sims passed through the terrible ordeal of a double pleuro-pneumonia, I stayed for fifteen nights by his bedside or lay upon a sofa in easy call of the suffering patient. As is common with doctors, he was a bad patient. I had been directed by Doctors Loomis and Janeway that no morphine should be administered if it could possibly be avoided. On one or two occasions, when he was suffering intensely, a small quantity had been given with gratifying effect to the patient. He insisted at one time that I should give him a hypodermic. I remonstrated mildly, telling him his condition was such that it was very dangerous to take it, and that I had positive instructions not to give him any that night. He raised such a clamor that at last I said: “Well, if you will have it, you must; but you must relieve me of all responsibility.” He answered: “All right; I’ll do it.” Having anticipated such a demand, I had already loaded a syringe with pure water, and took the bottle of Magendie’s solution, and went through the form of filling it with the proper quantity.

I stuck the needle into the patient’s arm, injected the contents of the syringe put everything away, went back to my sofa, lay down, and pretended to be asleep. He was quiet for five or ten minutes, then became somewhat restless; and soon after I heard him call, and walked around to the side of his bed. “How much Magendie did you give me?” he whispered. “Six minims,” I replied. Without taking his eyes from mine he pointed his finger at me and said, quietly, “Wyeth, that’s a lie, and you know it.” I am sure it was one of those white lies which will never be recorded against me, and I have every reason to know, after his convalescence and recovery, he had entirely forgiven me.—John Allan Wyeth, *With Sabre and Scalpel*, p. 368. 1924.

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CONSTRUCTIVE PROGRAM FOR MEDICAL CARE

AMERICAN MEDICAL ASSOCIATION

This platform was adopted by the Council on Medical Service and Public Relations and the Board of Trustees of the American Medical Association on June 22, 1945.

Preamble

The physicians of the United States are interested in extending to all people in all communities the best possible medical care. The Constitution of the United States, the Bill of Rights and the "American Way of Life" are diametrically opposed to regimentation or any form of totalitarianism. According to available evidence in surveys, most of the American people are not interested in testing in the United States experiments in medical care which have already failed in regimented countries.

The physicians of the United States, through the American Medical Association, have stressed repeatedly the necessity for extending to all corners of this great country the availability of aids for diagnosis and treatment, so that dependency will be minimized and independence will be stimulated. American private enterprise has won and is winning the greatest war in the world's history. Private enterprise and initiative manifested through research may conquer cancer, arthritis and other as yet unconquered scourges of humankind. Science, as history well demonstrates, prospers best when free and unshackled.

Program

The physicians represented by the American Medical Association propose the following constructive program for the extension of improved health and medical care to all the people:

1. Sustained production leading to better living conditions with improved housing, nutrition and sanitation which are fundamental to good health; we support progressive action toward achieving these objectives:

2. An extended program of disease prevention with the development or extension of organizations for public health service so that every part of our country will have such service, as rapidly as adequate personnel can be trained.

3. Increased hospitalization insurance on a voluntary basis.

4. The development in or extension to all localities of voluntary sickness insurance plans and provision for the extension of these plans to the needy under the principles already established by the American Medical Association.

5. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.

6. A survey of each state by qualified individuals and agencies to establish the need for additional medical care.

7. Federal aid to states where definite need is demonstrated, to be administered by the proper local agencies of the states involved with the help and advice of the medical profession.

8. Extension of information on these plans to all the people with recognition that such voluntary programs need not involve increased taxation.

9. A continuous survey of all voluntary plans for hospitalization and illness to determine their adequacy in meeting needs and maintaining continuous improvement in quality of medical service.

10. Discharge of physicians from the armed services as rapidly as is consistent with the war effort in order to facilitate redistribution and relocation of physicians in areas needing physicians.

11. Increased availability of medical education to young men and women to provide a greater number of physicians for rural areas.

12. Postponement of consideration of revolutionary changes while 60,000 medical men are in the service voluntarily and while 12,000,000 men and women are in uniform to preserve the American democratic system of government.

13. Adoption of federal legislation to provide for adjustments in draft regulation which will permit students to prepare for and continue the study of medicine.

14. Study of postwar medical personnel requirements with special reference to the needs of the veterans' hospitals, the regular army, navy and United States Public Health Service.

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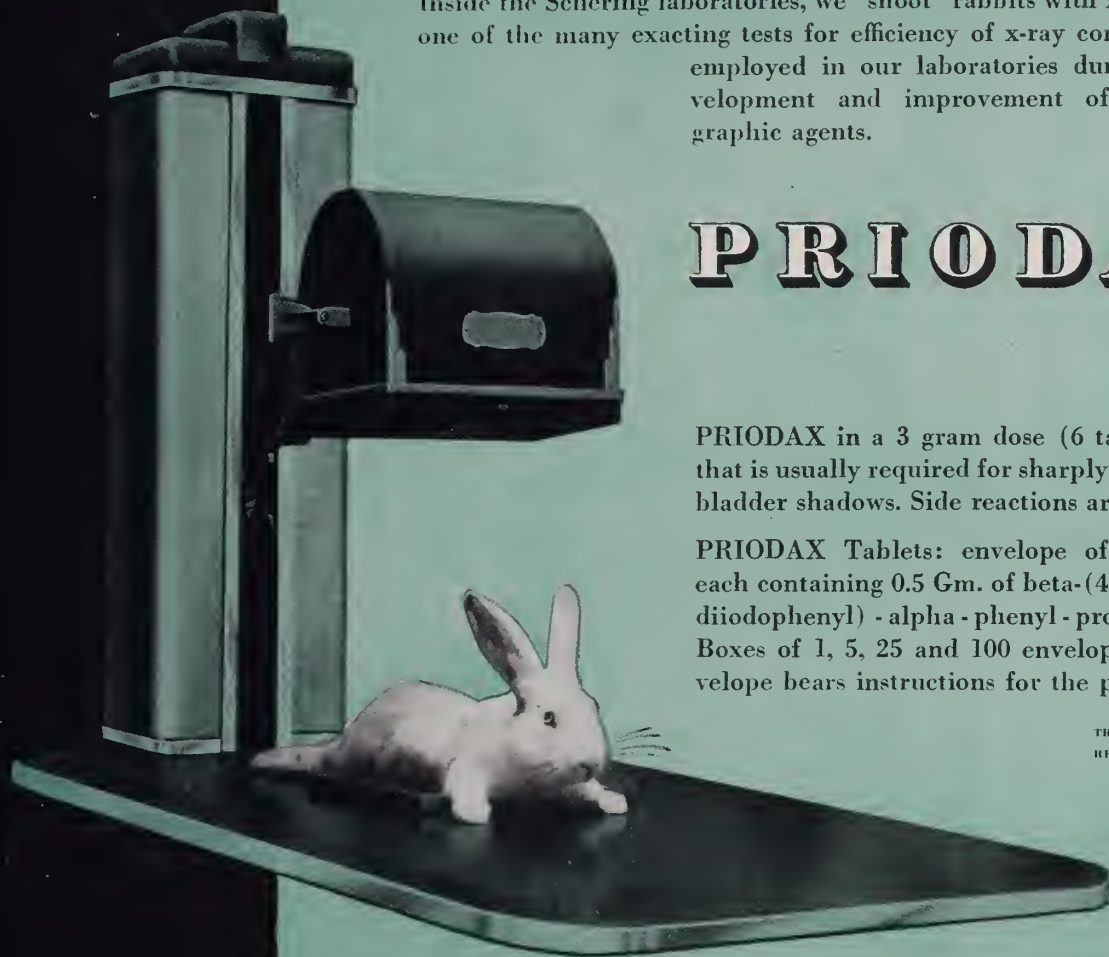
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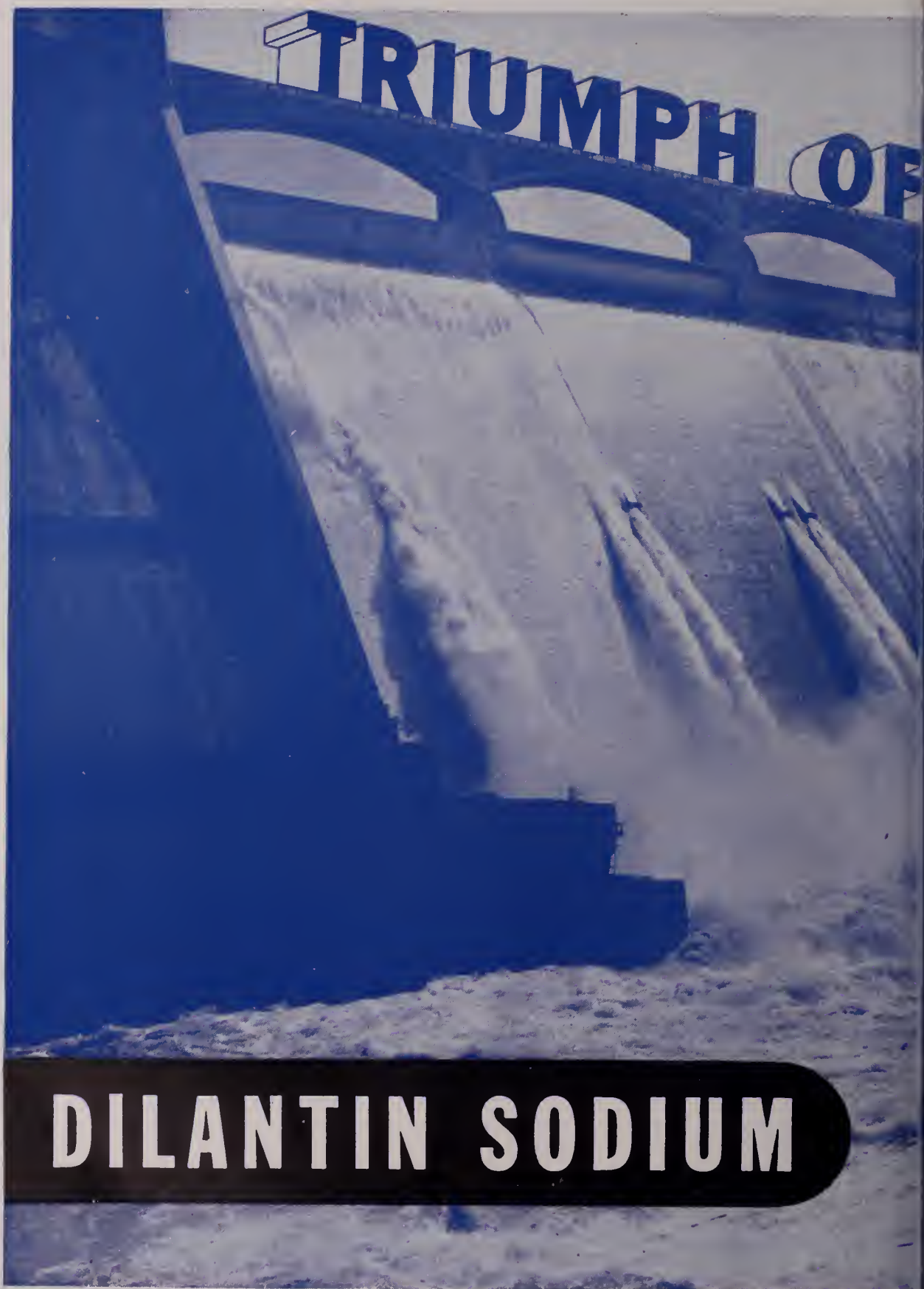
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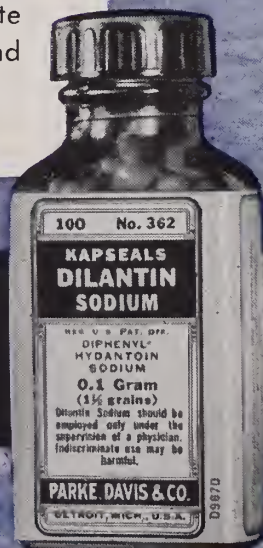
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★ FIGHTIN' TALK ★

21st Evacuation Hospital

The Daily Oklahoman, July 29, 1945.—Along with the infantry and the field artillery, the veteran 21st Evacuation hospital from Oklahoma is engaged in the old army game of sweating it out.

Since early in the war against Japan, the staff originally made up almost entirely of Oklahomans, has done almost double time. They have been square behind the infantry, the marines and the navy men through New Caledonia, Guadalcanal, Bougainville, and finally the Philippines. And there appears to be no letup for the outfit which was sponsored by the University of Oklahoma and sent overseas from the Frisco port of embarkation nearly three years ago.

Not many other hospitals have longer service overseas. The group left Oklahoma City on July 3, 1942, for San Luis Obispo where the 53rd Evacuation hospital was taken over. In August, after one month's training, they went to the great American desert. And in the middle of the home desert, with a group of enlisted men fresh from basic training and short on hospital training to the point of complete ignorance, the 21st staff began to sweat it out with Uncle Sam's soldiers.

They were there 13 months in spite of Uncle Sam's policy of not keeping soldiers in a desert for more than five months. The 21st group had to laugh about that one.

But the doctors were lucky. The enlisted men they drew were quick to adapt themselves to new situations. Many of them are still with the 21st, which was activated under that name shortly after reaching the desert.

They pulled away from Frisco in late August, 1943. It was long, unpleasant, uncomfortable and uneventful, but they finally pulled into New Caledonia. Shortly after they moved on to Guadalcanal.

In February, they were in route to Bougainville. An advance group of the staff and an engineer outfit had begun work clearing and draining an area and erecting tents for wards and surgery. A small surgery was constructed underground and covered with logs and heavy timbers. At first, there were air raids at night and Nip planes were commonplace. But the worst damage was the loss of sleep.

The staff was just going when the big Jap push began. The hospital was in an unenviable spot—some 800 to 1,000 yards from the front, and ahead of the artillery which was firing over their heads constantly.

"The shock tent was like a madhouse," writes CAPTAIN JIM M. TAYLOR, son of Dr. C. B. Taylor, Oklahoma City. "Every morning the place looked like a saloon after a big night. Plasma bottles piled high in the corner, piles of clothes cut off the wounded and a general litter of odds and ends filled the place.

"The casualties were pouring in just that fast.

"A whole blood bank was set up and donors poured in from line troops, service units and headquarters," he wrote. "Only universal donor types were used. At one time, relays of men drew blood for three days and nights as fast as the supply room could sterilize sets. Usually surgical men were waiting to snatch each bottle as it was drawn.

"A reserve of 14 pints was considered supreme opulence. It paid dividends. No one who required blood or plasma did without. Sulfa drugs were much in evidence and penicillin began to come into usage."

The 21st staff stayed in operation about 10 months and headed for the Philippines.

There is an old church which dates back to 1581 and the staff met civilization and women for the first time overseas. They even drew a consignment of American nurses.

But the patients increased also. The staff ran the range

from pediatrics to obstetrics. Manila was under fire when they moved in. But the 21st staff missed it.

The hospital group from Oklahoma has established a good record. The statistics show a low a mortality rate or lower than any hospital in the area.

As this is written, the veteran 21st Evacuation hospital from Oklahoma is sweating it out, as usual. They are building a new hospital, but who knows how long they will get to use it.

Where they go from the Philippines, the men themselves don't know.

LT. COLONEL WAYNE A. STARKEY, Altus, formerly of the Training Division, Operations Service in the Office of the Surgeon General, has been assigned overseas.

CAPTAIN JOHN V. CLARK, Oklahoma City, writes from the South Pacific:

"I am now commanding officer of this nice hospital and functioning here on this island so I should be settled down for a while and receive my Journal and letters from Dr. Tom more readily than in the past.

"By the way, the island has a predominance of Oklahoma doctors doing a swell job so it looks like this will be a nice place to settle down for a while.

"Some of our O. U. men have been out here over 40 months now and I sure would like to feel that I'm replacing one."

President Truman Boosts Combat Medic Pay

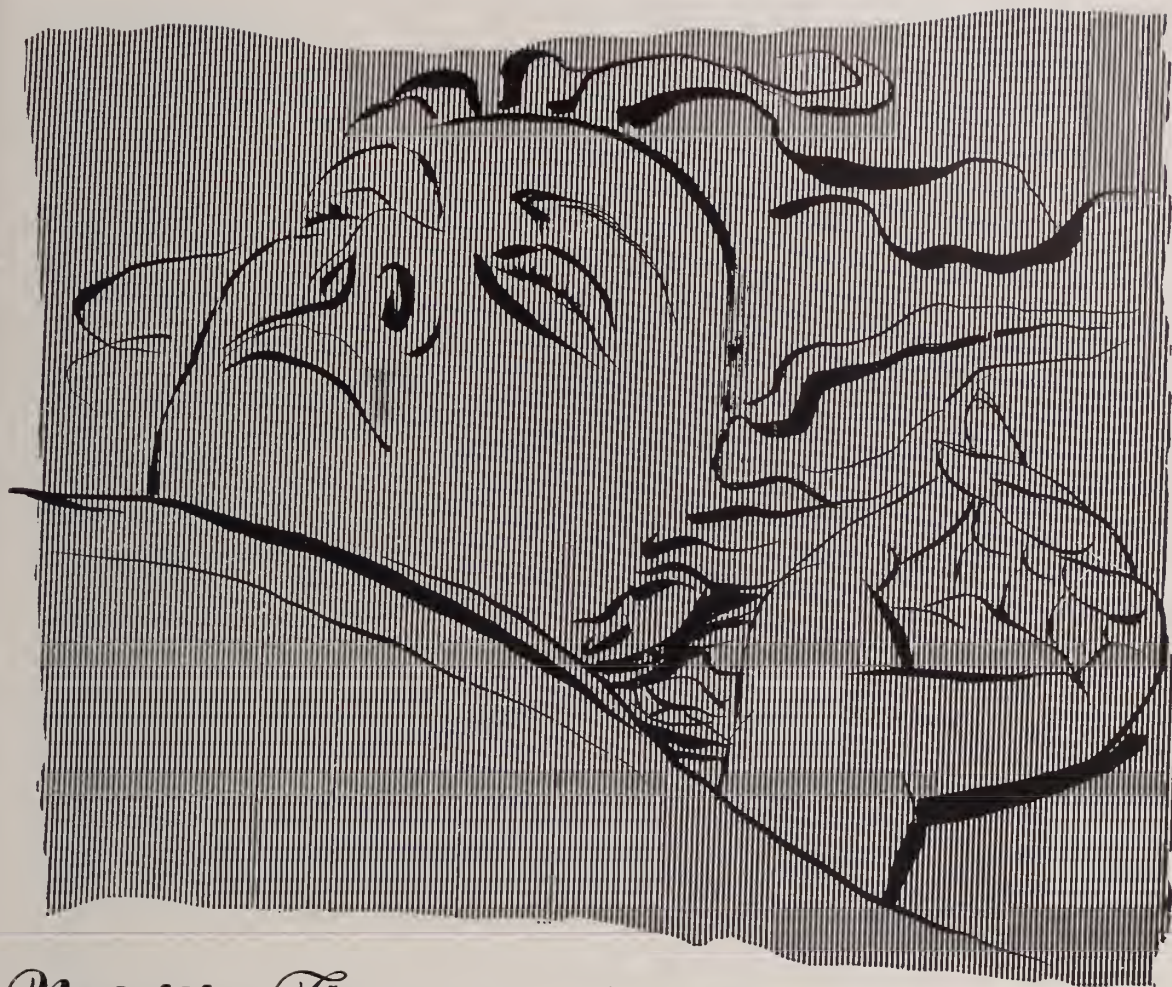
Enlisted medical corpsmen, better known as medics, assigned or attached to regimental or smaller combat units who are authorized to wear the Medical Badge will now receive an additional ten dollars a month under provisions of HR 2477 which the President signed on July 6. The Bill is largely an outgrowth of strong sentiment that medical men who are exposed to the same danger as infantrymen receive compensation similar to that which is awarded to wearers of the combat infantry badge.

COLONEL W. G. DUNNINGTON, Cherokee, is home following several months overseas. He will spend some time with his family before reporting for reassignment.

MAJOR L. P. SMITH, Marlow, recently returned from over two years overseas and is spending some time in Elmore City. He came by the Executive Office to see us which fact pleased us very much. He is, without any doubt, very glad to be home but doesn't know as yet where he is headed after his leave.

LT. GENE ARRENDELL, Ponca City, thinks about us once in a while and writes as follows: "Had the pleasure of several visits with 'Okie' doctors on Guam. Among them were HENRY FREEDE (Oklahoma City) and HAROLD DODSON (Haskell). The latter should be well on his way home by now—he keeps telling himself. For once, I must admit, Freede looked overworked. All of us were, during the Okinawa campaign and during the Iwo Invasion too. Incidentally, DR. TURNER BYNUM, of Chickasha was in the Okinawa invasion.

"Sorry there's no more to write about, but I want you to know how very much I enjoy your letters and the Journal. It's a pleasure and privilege to care for 'our boys' and mighty gratifying to know you're behind us and doing such a swell job. The recent legislation is truly wonderful! We're all very proud of the 'home folks,' and what you've done."



Nutritive Therapy

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Specific vitamin deficiencies, excepting in the case of vitamins D and K, are usually symptomatic of generalized nutritive failure. Many seeming contradictions in the literature become clear when this is understood. Use of the specific vitamins alone is at best symptomatic treatment and will not restore the patient to full health.

For further information write to Squibb Professional Service Dept., 745 Fifth Ave., New York 22, N. Y.

(1). Spies, Tom D.; Cogswell, Robert C., and Vilter, Carl: J. A. M. A. (Nov. 18) 1944. Spies, Tom D.: Med. Clin. N. Am. 27:273, 1943. (2). Jolliffe, Norman, and Smith, James J.: Med. Clin. N. Am. 27:567 (March) 1943.

SQUIBB *Nutritive Agents*

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

CAPTAIN J. E. LEVICK, Elk City, came by the office the other day and is to be retired from the Army. He is looking well and is enthusiastic about beginning practice again.

COLONEL E. ALBERT AISENSTADT, Picher, is back from overseas and is now retired from military service. At present he is spending some time at his place in Polo, Missouri, before beginning his practice again.

Dr. Aisenstadt writes as follows: "In February of this year when I was relieved from active duty, I had completed four years of service. Before going overseas, I filled a number of very interesting assignments at several stations from coast to coast during which time I had the pleasure of serving with quite a number of our mutual friends and colleagues from Oklahoma. I shall remember a number of such contacts with great pleasure and feel justly proud of the fine service that many of our doctors gave their country.

"Finally in March, 1944, I was given an assignment in the European Theatre and was flown across the Atlantic. After a short stay in London, I was assigned to the Communications Zone command which was to operate with the First Army during the invasion of Normandy. Among several assignments including the training of many of the General and Evacuation Hospitals assigned to our command, I was charged with taking charge of operations and plans division of the Medical Department of the CZ. This meant virtually the medical planning of the operation of the Invasion.

"After D day, it came our turn to cross the channel and participate in the Invasion. Soon after our landing the Commanding General sent me to Cherbourg, recently taken from the enemy, to establish and organize the entire medical set-up of the Cherbourg metropolitan area. It was a hard job with many a heartache and headache but the command seemed well satisfied since I received a commendation for the mission accomplished.

"I returned to the States on the hospital ship "Dogwood" during their maiden voyage, assigned to the O'Reilly General Hospital for a time and finally relieved from active duty."

INFORMATION BULLETIN FOR MEDICAL OFFICERS AVAILABLE THROUGH A. M. A.

The Bureau of Information was established by the Board of Trustees as approved by the House of Delegates of the American Medical Association to obtain reliable data on the educational, licensure, location and other desires and requirements of medical officers and to make the collected information available to physicians in military service. Several agencies of the Association, including the Committee on Postwar Medical Service, the Bureau of Information, the Council on Medical Education and Hospitals and the Bureau of Legal Medicine and Legislation, have taken part in gathering of information. This bulletin is designed to combine and abstract that information which is most desired by medical officers and to point out exactly how more specific and detailed data can be obtained.

The Bureau of Information of the A.M.A., 535 N. Dearborn St., Chicago 10, Ill., will be glad to furnish this pamphlet upon request.

Laennec's Method of Auscultation

This study he followed up with increased zeal and success, till his death in August, 1826. His first work was published in 1819, and from that date, his discovery made rapid progress over the continent, and in a few years over Great Britain. It has for many years been, in all the hospitals and public charities of Europe, as much a part of the examination of those suspected of thoracic disease, as the signs presented in the cough, pulse, sputa, etc.—*Library of Practical Medicine. Massachusetts Medical Society. Vol. VII. p. 46. 1936.*

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DO MORE THAN BEFORE — KEEP ON BUYING WAR BONDS

August 24, 1945

James D. Osborn, Jr., M.D., Secretary
Oklahoma State Board of Medical Examiners
Frederick, Oklahoma.

Dear Doctor:—

We enclose herewith copy of an article that will appear in the September, 1945 issue of Minnesota Medicine concerning the activities of Albert Broden of Milwaukee, Wisconsin, who represents himself to the public as a naturopathic physician.

The investigation disclosed that Broden has been arrested and convicted in the State of Texas for practicing medicine without a license and that he has operated in other states. He gives his home as 210 East Mason Street, Milwaukee, Wisconsin. You will note that Judge Selover told Broden to stay out of Minnesota.

This copy is sent to you so that you may have a little advance information about Mr. Broden if he should visit your state.

Yours truly,

Minnesota State Board of Medical Examiners
J. F. DuBois, M.D., Secretary.

Milwaukee Quack Denounced By Minneapolis Judge

On July 17, 1945, "Dr." Albert Henry Broden, "Naturopathic physician," 59 years of age, 210 East Mason Street, Milwaukee, Wisconsin, entered a plea of guilty, to an information charging him with practicing healing without a basic science certificate, in the district court of Hennepin County, Minnesota. Broden admitted under oath in court that he is not a "doctor." After being rebuked by the Hon. Arthur W. Selover, Judge of the District Court for his "chicanery," Broden was sentenced to a term of one year in the Minneapolis workhouse, the sentence being stayed on condition Broden "immediately leave the state and stay out."

Broden was arrested by Inspector Bernath of the Minneapolis Police Department after a joint investigation by the Minnesota State Board of Medical Examiners and the Minneapolis police department, on July 14 at the Hotel Andrews where he was conducting a so-called "clinic" in "bloodless surgery." Broden admitted to the Court that he charged \$150 for each person who attended his clinic. His record shows that he obtained \$600.00 from three chiropractors and one masseur. Broden represented himself as a "naturopathic physician."

Broden is an old hand at violating medical laws, having been arrested in 1929 at Duluth, Minnesota and convicted even though he took his case to the Supreme Court of Minnesota. According to the Texas State Board of Medical Examiners Broden has three convictions in that state for violating the medical laws. Broden told the Court he was born in Russia and entered the United States at Galveston, Texas in 1904. He also stated he worked as an orderly in an insane hospital in Texas; then four years as a painter in Texas and 18 years in the wall paper and paint business at Racine, Wisconsin. Broden claimed to be "naprapath" when arrested in Duluth in 1929.

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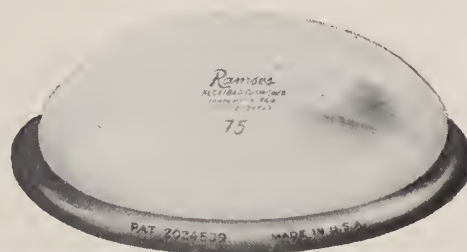


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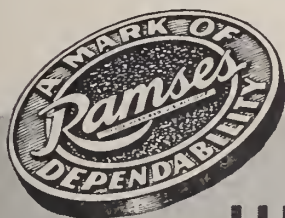
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Artificial Limb Concern Celebrates 85th Anniversary

J. E. Hanger, Inc., manufacturers of Artificial limbs, is, this week participating in a nation-wide celebration of the 85th year of its founding, and service to the armless and legless public. The present House of Hanger is the largest manufacturer of artificial limbs in the world, with offices in some 25 cities in the United States.

The business was established by J. E. Hanger who began to build the first Hanger in 1861. Being of an inventive turn of mind, and with some education in engineering, he made the first articulated artificial leg he ever saw. He invented a number of improvements during his lifetime, which are now generally used throughout the artificial limb industry. He manufactured, continually improved, and wore artificial limbs himself for almost three score years. His six sons were brought up in the business and it was when their training was completed that the business began to grow, with the result that units of the Hanger Organization are now serving disabled veterans and civilians in all of the States as well as Canada, England and France.

The London factory has continued to grow until it is the largest establishment manufacturing permanent artificial limbs in the world today, with an output of around 12,000 limbs a year, and an indicated output within the next year of 18,000 limbs. The British Ministry of Pensions, for perhaps 25 years, has contracted with Hanger for a term of years to supply permanent limbs to all British veterans and to maintain them at a minimum stated charge per year. The result has been that they get the best artificial limbs that can be manufactured, at a minimum price.

J. E. Hanger, Inc., has cooperated closely with the War and Navy Departments and with the Veterans Administration, to afford the best possible service to Veterans of World War I and World War II. At a three day conference, called by the National Research Council at the instance of the Surgeon General of the Army and Navy and attended by limb manufacturers, surgeons, scientists and government officials held in Chicago in

January of this year, adoption of improvements in vital sections of artificial legs, such as the hip joint, knee joint, and ankle assembly, were demonstrated by the artificial limb industry, were approved and recommended by the National Research Council for adoption by the Surgeon Generals of War and Navy Departments for use in temporary limbs for veterans.

Perhaps the most important of these improvements is the knee assembly designed by the Hanger Organization, which is now being produced for all Government contractors who are supplying above-knee temporary artificial legs to the seven amputation centers. In addition to this contract Hanger has been awarded contracts for socket patterns and master sockets to insure correct fitting of limbs at amputation centers; also for metal legs and for an improved Duralumin Mechanical Arm. The Hanger Company is also supplying on contract with the Surgeon General, artificial legs for disarticulation of the hip, known as the Tilting Table leg, which is one of the most difficult known amputations to equip satisfactorily.

At the request of the Surgeon General, the Hanger Organization has trained, without profit, enlisted men and non-commissioned officers in order to qualify them to serve in Government orthopedic shops and have designed and supplied tools and equipment for metal legs for use in government temporary limb shops.

Mr. McCarthy Hanger states, "We are determined that there shall be no let-down in the quality of Hanger Service to all Veterans, and that our past reputation for using only the best materials and workmanship shall continue. We are very proud of the fact that we have been commended by thousands of veterans who are wearing Hanger limbs. In our long service, we have rehabilitated more than a quarter of a million amputated American and Allied citizens and soldiers. We shall strive to follow the motto of Mr. Hanger, Senior, founder of our Company, who demanded, and got, continual improvement in quality and service for all those who wear Hanger limbs."

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MEDICAL ABSTRACTS

FRACTURES OF TRANSVERSE PROCESSES OF LUMBAR VERTEBRAE. Jesse T. Nicholson and John H. Allan. U. S. Naval Med. Bulletin, XLII, 780, 1944.

The authors cite nineteen cases of fractures of the transverse processes of the lumbar vertebrae treated aboard a hospital ship by local injections of procaine, and early mobilizing exercises. They consider the local contusion and tearing of muscle structure the important pathology. The quadratus lumborum originates from the crest of the ilium, and is inserted into all five lumbar transverse processes and into the twelfth rib. The iliopsoas also arise from all five vertebrae, and is inserted into the lesser trochanter of the femur. All previous treatment has included prolonged rest in bed, plaster jackets, braces, and inactivity, work being out of the question for three to six months. The authors stress the importance of getting men back to active duty on board ship.

In the author's cases, the transverse processes most frequently injured were those of the second, third, and fourth lumbar vertebrae. Treatment consisted of thorough infiltration of the soft tissues around the affected area with ten cubic centimeters of a 1 per cent solution of procaine. This was done every three days for four doses. Immediately following these injections, the patient performed exercises, such as (1) raising his back and shoulders up from the prone position; (2) rotating his shoulders first to the right and then to the left, while in a sitting position; (3) lateral bending; (4) touching the deck with his fingers from a standing position. Each of the exercises was done fifteen times, and was repeated daily.

The authors base their good results on Leriche's theory that procaine (1) eliminates the reflex arc of pain; (2)

activates early mobilization, and (3) interrupts vasomotor phenomena. They claim that active motion eliminates the scar which is brought about by exudate around the nerves and muscles.—E.D.M., M.D.

A NEWER METHOD IN THE TREATMENT OF FRACTURES OF THE OS CALCIS. Ben L. Schoolfield. ...Texas State Jr. of Medicine, XL, 294, 1944.

A method for internal fixation of fragments and for reduction of lateral displacement in fractures of the body of the calcaneus is described.

A vise, adequately padded, is applied and screwed up firmly over the sides of the displaced fragments just below the tips of the malleoli. The lateral displacement is reduced and checked roentgenographically. A Steinmann pin is then introduced through the middle of the posterior surface of the heel. It is directed obliquely forward and upward. Any upward tilting of the posterior fragment is corrected by depressing the drill and pin, after which the pin is driving into the anterior fragment for fixation. The vise is then removed, and a padded plaster-of-Paris dressing is applied to the limb, from the toes to just below the knee. During application of the plaster, the posterior part of the heel is depressed to maintain alignment, the forefoot is depressed in countertraction, while the foot is fixed at a right angle to the leg with a mild varus tilt.


After six weeks the cast is removed. If union of the fragments appears to be progressing, the Steinmann pin is taken out; otherwise it is left in the plaster is re-applied. Union is determined by roentgenogram.

Some swelling of the foot and ankle, with localized tenderness, may be expected. Weight-bearing is allowed when solid union has taken place.

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Pediatrics through Geriatrics

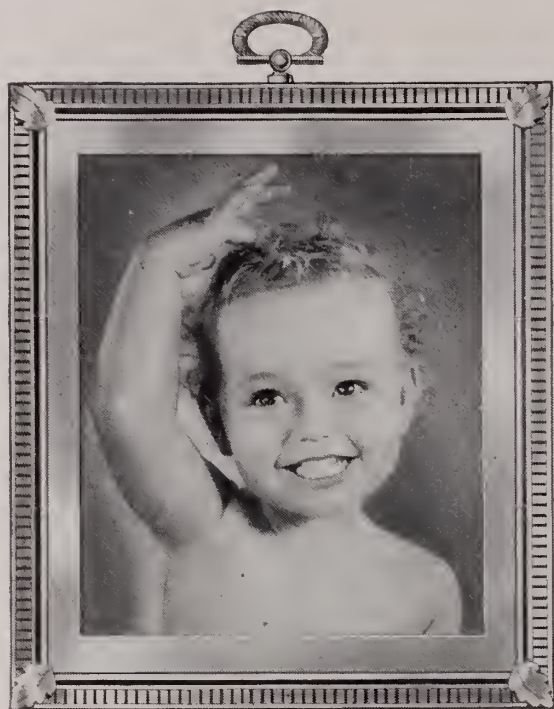
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The author has treated several cases of fracture of the body of the calcaneus in the past two years, with satisfactory results in all.

In some cases where the fracture line has penetrated the subtalar joint, traumatic arthritis has been observed, the result of improper reduction and fixation. Such an end result is unlikely, if restoration of the joint surfaces has been carried out along anatomical lines.—*E.D.M., M.D.*

SCHERING CORPORATION APPOINTS NEW SALES AND PROMOTION HEADS

Schering Corporation, manufacturers of endocrine and pharmaceutical preparations, having offices in Bloomfield and plants in Bloomfield and Union, New Jersey, has appointed Dr. John N. McDonnell to the newly created post of Director of Domestic Sales and Promotion of that company, succeeding Mr. Arthur F. Peterson, Manager of Domestic Sales Division, who has resigned. Mr. Herman W. Leitzow, eastern division manager since 1944, has been made assistant to Dr. McDonnell. Mr. George C. Straayer, manager of the professional service division, will continue in that post and in addition will devote part of his time to the development of field operations for Schering.

The promotion of Mr. Leitzow and Mr. Straayer is in line with the present program of expansion of Schering's manufacturing and leadership in important pharmaceuticals for the medical profession. A native of Minnesota and a graduate of the state university there, Mr. Leitzow engaged in retail drug practice for a number of years before joining the Schering staff. Mr. Straayer came to his present position after several years of retail and industrial experience. He received his professional and business training in Michigan, and has been associated with Schering since 1939.

Dr. McDonnell, who has been for some years technical and marketing consultant to the pharmaceutical industry will coordinate the sales development and promotion activities of Schering. For the past four years head of research of the Drugs Branch of the War Production Board, he was recently national director of civilian penicillin distribution. Dr. McDonnell is editor of "American Professional Pharmacist" magazine of New York and a member of the faculty of pharmacy and business at the Philadelphia College of Pharmacy and Science. He pursued graduate studies there and at the University of Pennsylvania in technical and business subjects, and is a member of a number of professional societies and associations. He has been engaged in retail practice and associated with a number of industrial firms in the pharmaceutical field. His home is in Meadowbrook, Pennsylvania.

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Bartlett On Certainty in Medicine

It had been my wish or purpose to produce striking and startling effects, by more vivid and dramatic representations of the achievements of medical science, I could easily have done so, and without traveling out of the records. I could have shown our science, with its nice and delicate senses, catching the first faint, ominous sign of commencing tuberculous deposition in the pulmonary tissue, watching and following its increase and development from week to week, and from month to month; noting exactly all its changes—its softening—its discharge from the body—and then counting the cavities left in the lung, and defining their boundaries;—taking the exact gauge and dimensions of the living and beating heart, measuring the variations in the thickness of its walls, and the capacity of its cavities, marking out the circumference of its orifices—as they are enlarged or narrowed by disease.—and detecting every disturbance in the play and adjustment of its delicate valves;—seeing in the slight frown on the forehead of the young child, the end from the beginning, the dim cloud on the horizon, no bigger than a man's hand, that shall yet so soon spread its sable pall over the sky, and blot out the light of life. But my object has been to present a plain, unvarnished, and faithful statement of the nature and extent of our knowledge of disease, avoiding even the appearance of exaggeration, and keeping carefully out of the picture, not only all false, but even all high coloring.—*Elisha Bartlett. An Inquiry into the Degree of Certainty in Medicine. 1938.*

The Higher Civilization

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¹Co Tui, et al: Ann. Surg., 121:228, 1945.

²Cannon, P. R., et al: Ann. Surg., 120:514, 1944.

³Rose, W. C., et al: J. Biol. Chem., 146:683, 1942; 148:457, 1943.

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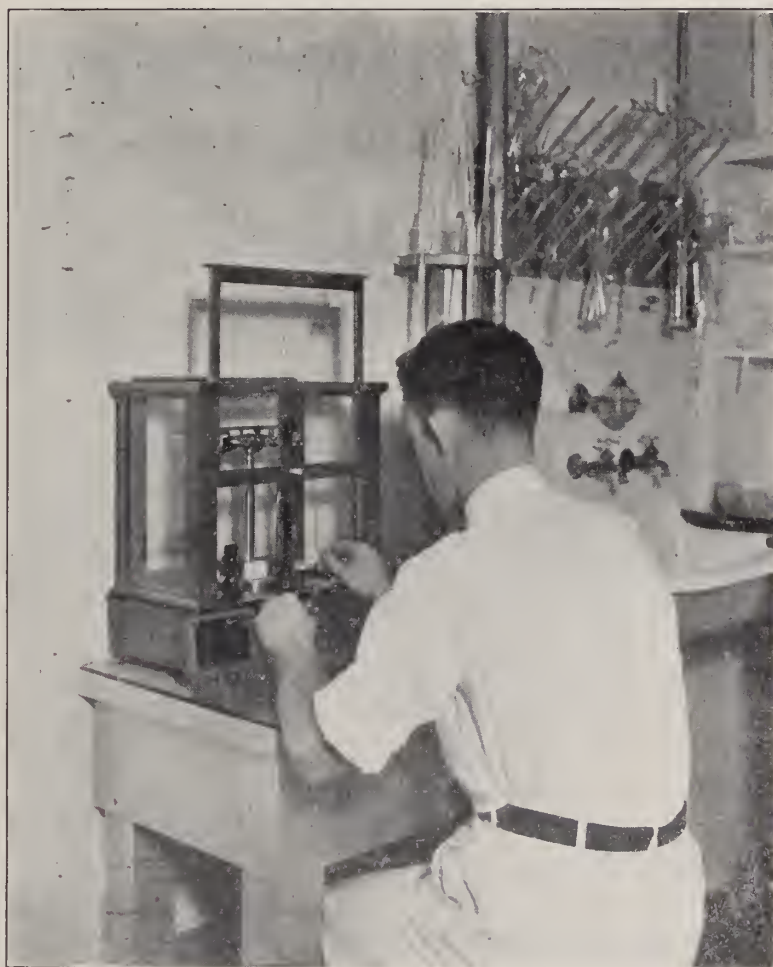
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**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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Beckham.....	G. H. Stagner, Erick	O. C. Standifer, Elk City	Second Tuesday
Blaine.....	Virginia Curtin, Watonga	W. F. Griffin, Watonga	
Bryan.....	W. A. Hyde, Durant	W. K. Haynie, Durant	Second Tuesday
Caddo.....	C. B. Sullivan, Carnegie	P. H. Anderson, Anadarko	
Canadian.....	P. F. Herod, El Reno	A. L. Johnson, El Reno	Subject to call
Carter.....	J. L. Cox, Ardmore	H. A. Higgins, Ardmore	Second Tuesday
Cherokee.....	P. H. Medearis, Tahlequah	W. M. Wood, Tahlequah	First Tuesday
Choctaw.....	O. R. Gregg, Hugo	E. A. Johnson, Hugo	
Cleveland.....	Iva S. Merritt, Norman	O. M. Woodson, Norman	Thursday nights
Comanche.....	W. F. Lewis, Lawton	W. C. Cole, Lawton	
Cotton.....	G. W. Baker, Walters	Mollie F. Seism, Walters	Third Friday
Craig.....	Lloyd H. McPike, Vinita	J. M. McMillan, Vinita	
Creek.....	C. R. McDonald, Mannford	Philip Joseph, Sapulpa	
Custer.....	T. A. Boyd, Weatherford	W. H. Smith, Clinton	Third Thursday
Garfield.....	P. W. Hopkins, Enid	John R. Walker, Enid	Fourth Thursday
Garvin.....	Marvin E. Robberson, Wynnewood	John R. Callaway, Pauls Valley	Wednesday before Third Thursday
Grady.....	Roy E. Emanuel, Chickasha	Rebecca H. Mason, Chickasha	Third Thursday
Grant.....	I. V. Hardy, Medford	F. P. Robinson, Nash	
Greer.....	R. W. Lewis, Granite	J. B. Hollis, Mangum	
Harmon.....	W. G. Husband, Hollis	R. H. Lynch, Hollis	First Wednesday
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Hughes.....	H. A. Howell, Holdenville	Imogene Mayfield, Holdenville	First Friday
Jackson.....	C. G. Spears, Altus	E. A. Abernethy, Altus	Last Monday
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Kiowa.....	J. P. Braun, Hobart	William Bernell, Hobart	
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Logan.....	J. L. LeHew, Jr., Guthrie	J. E. Souter, Guthrie	Last Tuesday
Marshall.....	J. L. Holland, Madill	J. F. York, Madill	
Mayes.....	S. C. Rutherford, Locust Grove	B. L. Morrow, Salina	
McClain.....	J. E. Cochrane, Byars	W. C. McCurdy, Jr., Purcell	
McCurtain.....	J. T. Moreland, Idabel	R. H. Sherrill, Broken Bow	Fourth Tuesday
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Muskogee-Sequoyah			
Wagoner.....	H. A. Scott, Muskogee	D. Evelyn Miller, Muskogee	First Monday
Noble.....	D. F. Coldiron, Perry	Jess W. Driver, Perry	
Okfuskee.....	W. P. Jenkins, Okemah	M. L. Whitney, Okemah	Second Monday
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Okmulgee.....	W. M. Haynes, Henryetta	J. C. Matheney, Okmulgee	Second Monday
Osage.....	G. K. Hemphill, Pawhuska	C. R. Weirich, Pawhuska	Third Monday
Ottawa.....	P. J. Cunningham, Miami	L. P. Hetherington, Miami	Second Thursday
Pawnee.....	E. T. Robinson, Cleveland	R. L. Browning, Pawnee	
Payne.....	Haskell Smith, Stillwater	A. C. Reding, Stillwater	Third Thursday
Pittsburg.....	L. N. Dakil, McAlester	A. R. Stough, McAlester	Third Friday
Pontotoc-Murray.....	Ollie McBride, Ada	R. H. Mayes, Ada	First Wednesday
Pottawatomie.....	Chas. W. Haygood, Shawnee	Clinton Gallaher, Shawnee	First and Third Saturday
Pushmataha.....	John S. Lawson, Clayton	B. M. Huckabay, Antlers	
Rogers.....	K. D. Jennings, Chelsea	Chas. L. Caldwell, Chelsea	Third Wednesday
Seminole.....	A. A. Walker, Wewoka	Mack I. Shanholtz, Wewoka	Third Wednesday
Stephens.....	W. K. Walker, Marlow	E. H. Lindley, Duncan	
Texas.....	R. G. Obermiller, Texhoma	Evelyn Rude, Guymon	
Tillman.....	W. A. Fuqua, Grandfield	O. G. Bacon, Frederick	
Tulsa.....	H. A. Ruprecht, Tulsa	E. O. Johnson, Tulsa	Second and Fourth Monday
Washington-Nowata.....	J. V. Athey, Bartlesville	S. A. Lang, Nowata	Second Wednesday
Washita.....	A. S. Neal, Cordell	James F. McMurphy, Sentinel	
Woods.....	O. E. Templin, Alva	I. F. Stephenson, Alva	Last Tuesday
Woodward.....	Roy Newman, Shattuck	C. W. Tedrowe, Woodward	Odd Months Second Thursday

*(Serving in Armed Forces)

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Number 10

The Familial Aspects of Gout, Diabetes Mellitus and Obesity*

WILLIAM K. ISHMAEL, MAJOR, M.C., A.U.S.
OKLAHOMA CITY, OKLAHOMA

The familial interrelationship of obesity to both gout and diabetes mellitus has long been recognized. Also, the familial incidence of diabetes in diabetic families and the occurrence of gouty arthritis in gouty families is well known, but the existence of gout in diabetic families has not been emphasized.

Charcot¹ held that the inheritance of a common underlying character could lead to the development of both diseases, however, Hoslin² reports that only one diabetic out of fifteen hundred had gout concurrently with diabetes. Woodyatt³ and Pratt⁴ also doubt that any association exists between these two diseases.

In obtaining the family histories of patients with gout, the occurrence of diabetes in other members of the family seemed strikingly frequent. Since these two diseases are of metabolic origin and in view of the fact that they rarely appear concurrently in the same patient, their relationship seemed worthy of further investigation.

METHOD OF INVESTIGATION

The pitfalls encountered in obtaining an accurate family history are well known. Frequently there are patients who know little or nothing about even their immediate family. There also exists the possibility that the disease is inherent, but as yet has produced no symptoms. Also present is the fact that lack of diagnosis frequently causes errors in the statistics obtained. This especially is true in gout.

In this series, the family histories of 50

patients diagnosed as having gouty arthritis were investigated in the following manner:

1. Only patients with the diagnosis therapeutically proved were included.
2. To avoid duplication, members of the same family were not used.
3. To eliminate "selecting isolated instances to prove a point," all patients with gout seen at the McBride Clinic and the Oklahoma State University Hospital during a three years period, who met the first two specifications, were used. In addition, six patients subsequently seen in the military service are appended.
4. "Relatives" investigated consisted of siblings, children, the parents and their siblings.

Controls were arranged into three groups:

1. Fifty patients with diabetes mellitus were investigated in the same manner as were those with gout. In questioning the subjects, the incidence of obesity was considered in addition to that of gout and diabetes. They were asked to report also the incidence of any other types of arthritis or rheumatic disease.
2. Fifty patients with various types of arthritis other than gout were studied in a similar manner. Approximately 75 per cent of this group were classed as rheumatoid arthritis.
3. Fifty consecutive patients admitted to the Bone and Joint Hospital, Oklahoma City, with uncomplicated fractures were included to represent normals.

RESULTS OF INVESTIGATION

The findings are tabulated in charts one to four. These are summarized as follows:

*From the Department of Internal Medicine of the University of Oklahoma School of Medicine, The McBride Clinic, Oklahoma City, and the Medical Service of a Station Hospital. Approved as amended by the Public Relations Department of the U. S. Army.

CHART NO. 1

Family History of Fifty Patients With Gouty Arthritis

		Gouty Diabetes Arthritis	Obesity	Other Forms Arthritis
Number with some				
Family Incidence	19	9	34	32
Number with Incidence				
In Immediate Family	13	8	31	30
Number with Incidence				
In only Parent's				
Families	6	1	3	2
Number with Incidence				
In only one member of				
Family	12	6	3	11
Number with Incidence				
In more than one mem-				
ber of Family	7	3	31	21

Thirty-eight per cent of the patients with gouty arthritis (Chart No. 1) reported diabetes mellitus in their families. Eighteen per cent of the group knew of definite gout in their families and 64 per cent reported some form of arthritis. Sixty-eight per cent reported obesity as a family trait.

CHART NO. 2

Family History of Fifty Patients with Diabetes Mellitus

		Gouty Diabetes Arthritis	Obesity	Other Forms Arthritis
Number with some				
Family Incidence	22	5	41	33
Number with Incidence				
In Immediate				
Family	18	4	36	31
Number with Incidence				
In only one member				
of Family	7	4	8	19
Number with Incidence				
In only Parent's				
Family	4	1	5	2
Number with Incidence				
In more than one mem-				
ber of Family	15	1	33	14

In the group with diabetes mellitus (Chart No. 2) 44 per cent had this disease in their families. It is surprising to note that in 10 per cent of these families, gout was known to exist. Obesity was present in 94 per cent of the families and 66 per cent reported the existence of some form of arthritis.

CHART NO. 3

Family History of Fifty Patients with Arthritis other than Gout

		Gouty Diabetes Arthritis	Obesity	Other Forms Arthritis
Number with some				
Family Incidence	4	2	28	33
Number with incidence				
in immediate family ..	3	0	22	32
Number with Incidence				
In only parent's				
Family	1	2	6	1
Number with incidence				
In only one member				
of Family	3	2	12	13
Number with incidence				
In more than one mem-				
ber of Family	1	0	16	20

In the group of arthritics (Chart No. 3), 8 per cent reported diabetes in the family, 4 per cent knew of gout, 56 per cent listed obes-

ity and in 66 per cent there existed some form of arthritis.

Chart No. 4 represents the normals. None of these patients were suffering from diabetes, rheumatism or gout, however, obesity was not considered. Their histories revealed that 6 per cent had diabetes in the family, 2 per cent knew that gout existed and 40 per cent reported the incidence of obesity. Some form of rheumatism existed in the families of 40 per cent of this group.

CHART NO. 4

Family History of Fifty Patients with Uncomplicated Fractures

		Gouty Diabetes Arthritis	Obesity	Other Forms Arthritis
Number with some				
Family Incidence	3	1	20	20
Number with Incidence				
In Immediate				
Family	2	0	17	18
Number with Incidence				
In only Parent's				
Family	1	1	3	2
Number with Incidence				
In only one member				
of Family	2	1	10	11
Number with Incidence				
In more than one mem-				
ber of Family	1	0	10	9

DISCUSSION

These results indicate that patients with gout, as well as those with diabetes mellitus, have a familial background of diabetes with relatively the same incidence. Statistics based on a series of 50 patients are very hazardous, however, subsequent observations on military personnel tend to confirm these findings. Of 7768 patients admitted to an army air force station hospital in the zone of interior, 6 had gouty arthritis (Chart No. 5). Of this 6, 5 had diabetes mellitus in their immediate family and all listed obesity as a familial characteristic. All of these patients were robust in appearance and were of more than average weight. Five of the 6 had classical podagra and the sixth, who complained of a "sprained" ankle with history of trauma, gave history of a previous disabling attack of severe pain and swelling in his great toe. All had a hyperuricemia.

The family history of a 33 year old white enlisted man of German extraction (figure No. 1) is listed as an example: Mother — died as a result of diabetes mellitus; Mother's mother — died as result of diabetes mellitus; Mother's sister — died as a result of diabetes mellitus: Sister — "she has had trouble with her foot just like mine."

In view of the fact that gouty arthritis and diabetes mellitus differ so in their clinical appearance, it is interesting to consider some of the features which these two diseases

CHART NO. 5
Family History of Six Patients in Military Service with Gouty Arthritis

	Incidence of Diabetes	Incidence of Gout	Incidence of Obesity
No. 1	Mother	None	Mother Mother's Mother Two Sisters
No. 2	Father	None	Father Father's Father One Sister
No. 3	Father	None	Father Father's Mother Father's Two Sisters
No. 4	Mother Mother's Mother Sister	Sister	Mother Mother's Mother Mother's Sister Sister
No. 5	Mother	None	Both Father and Mother's 2 Siblings
No. 6	None	None	Mother Mother's 2 Siblings and Mother
TOTALS	5	1	6

of metabolism have in common.

1. There exists a faulty metabolism of fats.⁵ Furthermore, ketosis is capable of precipitating the usual complications in either disease.^{6 3}
2. These clinical syndromes usually appear when the patient is past 35 or 40 years of age.^{7 2}
3. The same factors are likely to produce exacerbations. Infections, surgical procedures, exhaustion, ketosis, emotional upsets and exposure,^{2 7 3} have all been reported.
4. Arteriosclerosis results with high frequency.^{2 3 5 7}
5. The younger the patient at the onset of either disease, the more severe the course is apt to be.^{7 2 3}
6. Nephritis is a likely final complication in both diseases.^{2 3 5 7}
7. Obesity occurs with striking frequency in the families.² The patients themselves are apt to be of more than average weight at the onset.
8. Furunculosis³ appears frequently as a complication and occasionally leads to the diagnosis of diabetes mellitus or gout.

These facts are interesting, but at present no conclusions can be drawn in regard to the etiological significance of gout occurring in diabetic families. However, in a patient suspected of having gouty arthritis, the existence of diabetes in his family is of diagnostic significance and can be utilized in differentiating this disease.

CONCLUSIONS

1. Forty-two and eight-tenths per cent of 56 patients with gouty arthritis investigated in this series were from diabetic families.
2. Seventy-one and four-tenths per cent of this group listed obesity as a familial characteristic.



Figure 1.

3. Similarities between gout and diabetes mellitus are pointed out, yet no conclusions can be reached regarding the etiological significance of the tendency of these two diseases, along with obesity, to occur in the same families. However, it is proposed that the existence of a family background of diabetes mellit-

tus is significant when evaluating the features diagnostic of gout.

ACKNOWLEDGEMENT

Appreciation is expressed to Bert F. Keltz, M.D., Oklahoma City, for his aid in the studies made on the control group of diabetic patients.

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Fluorescent Lighting and It's Effect Upon Visual Function

JAMES P. LUTON, M.D.

OKLAHOMA CITY, OKLAHOMA

In the seven years since the introduction of fluorescent lighting, considerable interest in its development has been manifest, but, strange to say, little research has been evident on the part of the medical profession, including the ophthalmologist. Aside from a brief, favorable report published in the Journal of the American Medical Association a few years ago, a few brief, but not necessarily scientific papers, and an occasional short discussion at meetings or conventions, we, in the profession have very little knowledge of a rather important question daily affecting human welfare. Naturally the lighting engineers have taken a great interest in this subject, and it would seem that they have made the nearest scientific approach to the subject of anyone concerned. These men have an excellent knowledge of light and lighting principles and some of them have a surprising store of knowledge in the fields of anatomy, physiology and psychology. We must not forget, however, that their knowledge on the latter subjects is more theoretical than practical and that they may sometimes be influenced by a desire to sell something new to the public. Second only to the lighting engineers in championing fluorescent lighting is the dental profession. It is interesting to note that one of the most comprehensive papers written on this subject was produced by a dental surgeon and published in the Journal of the American Dental Association. (1) Many other articles have been published by that group and considerable work has been done in adapting fluorescent light-

ing to dental equipment. The explanation for this turn of events probably lies in the fact that almost all of the dentists work depends upon good visual acuity over prolonged periods and that the fluorescent lamp in its present form is more or less readily adaptable to his needs. On the other hand, the ophthalmologist, who should be much more interested in the subject of lighting in general, must use a variety of lights for his work, many of which cannot make use of the fluorescent lamp in any of its present forms.

The fluorescent lamp consists of a cylindrical frosted glass tube of variable size and length, containing mercury vapor and lined with certain elements in powdered form. At each end of the tube there is an electrode with heating and starting unit for setting up and maintaining a flow of electrical current through the mercury vapor within the lamp. Action of this current upon the powdered chemical lining of the tube causes the particles of powder to fluoresce, thereby producing light throughout the entire length and inner circumference of the lamp. (2) The light produced is uniformly distributed over a relatively wide area in contrast to the conventional incandescent lamp, thus eliminating the intense focal brightness and concentrated heat of the latter type of lamp. The day-light fluorescent lamp produces light nearer natural day light than any other artificial light so far produced. It produces a continuous spectrum, containing all of the visible wave-lengths of light from ultra-violet at about 3800 A. U. to infra-red at 7500

A. U. with the exception that there are irregular bands or so-called mercury lines at which points in the spectrum there is a considerable excess of energy. (3) These bands are four in number, located approximately as follows: a small excess in the violet 4047 A. U. area, a marked increase in the blue 4358 A. U. area, a slightly less increased band in the green 5461 area, and a very small peak in the red 5780 area. These lines or bands are narrow and are comparable to the interrupted light of the old Cooper-Hewitt mercury lamp which has been in use for years. The spectrum of the fluorescent lamp might then be favorably compared to a combination of natural daylight and a mercury arc lamp. The light in question is then made up of a continuous irregular spectrum differing from that of daylight — for all practical purposes — only to the extent of the four mercury lines. It is of interest to note in passing that the spectrum of this lamp can be varied almost at will by changing the chemical dust lining of the tube so that any color or combination of colors can be used without the aid of filters. Another advantage of the lamp is that any type of glass or filter may be used in the lamp so that the spectrum can be controlled and any undesirable rays can be eliminated from the light.

The eye, as we know, is a small camera-like organ for the purpose of receiving and focusing rays of light upon the sensory extension of the brain, the retina, which in turn transforms the sensations thus received into nervous impulses which are transmitted by way of the optic nerve to the visual centers of the brain. There is little argument regarding the mechanisms of accommodation and of adaption to light both by pupillary control and by physiological changes which light brings about within the retina itself. We also have considerable data regarding the reflection, absorption, refraction, and dispersion of light by the various media of the eye and the effects of light upon these tissues. The ocular media, that is, the cornea, aqueous, crystalline lens and vitreous, transmit all except eight per cent of the visible spectrum. We can consider then that only eight per cent of the visible light rays tend to have any effect upon these media, since it is only through absorption that they can have any effect upon such tissues. Rays which are transmitted, reflected or diffused do not have any effect upon the media through which they pass. This does not mean, of course, that all of the light in this eight per cent is harmful because the effect it exerts on the tissues by which it is absorbed may indeed be beneficial. It is further known that the greatest absorption takes place in the ultra-violet

and the infra-red portions of the spectrum, in so far as the ocular media are concerned. It follows then that we should be on guard for harmful effects in these two general areas of the spectrum when evaluating the effects of any given light upon the eye.

When absorption of light in excess takes place within the ocular media it may have one of three effects: 1. Thermal effect in which there is coagulation and destruction by heat as in infra-red lesions; 2. Photo-chemical (abiotic) effect in which there is a transfer of energy to the molecules or their parts so that they may be shaken apart, even to the point of destruction; 3. The rays may produce fluorescence, in which case the molecules of the tissues themselves become sources of light. It is still a debatable question whether this is a protective mechanism in which the harmful short rays are changed to less harmful, longer rays, or whether there is some destruction of the tissue by this particular phenomenon.⁴

As stated above, the most of the light entering the eye (92 per cent) passes on to the retina where it is more or less concentrated and where absorption is completed. In the case of the retina there may be a thermal effect, an abiotic effect and the excitation of the sensation of vision. This last effect is peculiar only to retinal tissue. The energy reaching the retina which is not consumed by producing the sensation of vision is absorbed by the retina. That excess energy in the form of short waves is absorbed by the proteins of the cells in its anterior layers where it may produce an abiotic effect similar to that described as taking place in the media. The long waves, both infra-red and the remaining visible rays, pass through the several layers of the retina and are absorbed by the pigment where it is degraded into heat. Here it may produce a thermal lesion if too concentrated. The statement has been made that a sufficient amount of the ultra-violet light cannot reach the retina to cause damage (Verhoeff and Bell, 1916), Siegfried, 1928), on short exposure of that light. Nevertheless, in experiments (Duke-Elder) and in practice (Berens and McAlpine — 1944), (5), there has been sufficient evidence that such injury does actually take place. Duke-Elder states that abiotic changes may not necessarily become evident immediately, but that they may be delayed as much as six or eight hours. This, then, leaves the question open of accumulative effect both from prolonged and from repeated exposures to light.

Our problem then resolves itself into the determination of type percentages and intensities of rays given out by the lamp as used in the average type of work and a comparison of these with the tolerance of the ocular

tissues to those figures. The lighting engineers are ahead of us in that they are able to furnish the exact figures with regard to the light, but we do not have available any equivalent figures regarding the tolerance of the eye. We do know that the eye evolved over a period of many, many years in daylight and sun-light which is many times brighter than any of the artificial lights thus far in use. We know also that the eye has remarkable powers of adapting itself to the extremes from bright sunlight to dark without apparent ill effect, so we may conclude that it certainly should be able to adapt itself to the spectrum and intensity of the fluorescent light at present in use. The one exception to this may be the excess energy in the so-called mercury lines of the lamp which have previously been described. So far as this writer has been able to find in the literature and by observation there is no evidence of pathology from this source, but it may bear further investigation.

The lighting engineers are inclined to believe — and not without reason — that most, or all of the complaints laid at the door of this new type of lighting are due to poor engineering psychological reaction to any drastic change. (6) In other words they say that the fluorescent lamp should be properly shaded from view, just as any other type of lamp, that glare and reflection should be eliminated and that sufficient fixtures should be used at proper height to give about thirty-five (35) to fifty (50) foot candles of light evenly distributed throughout the area in which the light is being used.

We can agree with the engineers that the psychological factor is important especially during times of stress such as we have had for the past four or five years. There is always a tendency on the part of some individuals to react unfavorably to any new circumstance and when large numbers are placed in new positions in a more or less regimented state, a few of the weaker ones will begin to complain. Their complaints, when referable to the eyes, may be due to one of any number of causes which they do not understand, and it is only natural for them to reach the conclusion that the new type of light is the underlying cause of their troubles. It is surprising how wide-spread the effect may be in the group as a whole, when one or two in that group begin registering some complaint.

A phenomenon of the fluorescent lamp which deserves some attention is the stroboscopic or flickering effect resulting from the alternating current on which the lamp depends for its energy. This flicker is due to pulsation of the current which allows the light to disappear and reappear approximately 120 times a minute. When the light strikes

the retina at a point or points other than the macular area this variation is quite noticeable, when the eye or the object incident to the eye is in motion it is greatly exaggerated, amounting to a series of images in rapid succession. While this condition in itself is not particularly harmful, it does have a tendency to bring about ocular fatigue and in some cases where fine moving work is necessary it may even become quite confusing. This objectionable feature has been largely eliminated in the improved lamps by placing them in pairs, so that the two lamps alternate in opposite phases, thereby causing one lamp to be lighted while the other is in its state of regression.

Dr. Harmon of the Texas State Department of Health has raised the question of the possibility of the light absorbing excessive amounts of vitamins, thereby bringing about a state of avitaminosis within the ocular media. He points out the riboflavin deficiency. He does not include any evidence or controls to prove that this condition is peculiar to the fluorescent lamp, and it has been reported by others as being due to sunlight reflected from water, snow, sand, etc.

In conclusion I should like to give my reactions to the light, based on observation and upon the available information at the present time. I have not seen any signs of pathology or any reports of pathology in the eye, other than a mild conjunctivitis and, perhaps, a superficial keratitis which could be attributed to the use of the light in the usual form. There is a need for further investigation with regard to the effects of excess energy due to the mercury lines and for investigation of the infra-red and ultra-violet energy beyond the limits of the visible spectrum. I believe it is reasonable to consider the lamp safe for general use, and that it will be a valuable asset to the field of artificial lighting.

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CLINICAL PATHOLOGIC CONFERENCE

Presented by the Department of Pathology of the University of Oklahoma School of Medicine

MAJOR WILLIAM K. ISHMAEL AND DR. BELA HALPERT.

DOCTOR HALPERT: The case for consideration today presents a diagnostic problem of no mean proportions. I am sure that you have determined this for yourselves, however, in your study of the case history which was presented to all of you two days ago. We are particularly fortunate today in having with us Major William K. Ishmael, who is on a special tour of duty at this University and who has agreed to discuss the clinical aspects of this case.

PROTOCOL

Patient: G. R., white male, age 59; admitted 12-11-44; died 1-20-45.

Chief Complaint: Ascites and pedal edema of 12 years duration and mass in epigastrium for one year.

Present Illness: In 1932 the patient developed jaundice, ascites, pedal edema, marked loss of weight, and anorexia requiring confinement to bed for 18 months. Over a two year period, 96 paracenteses were performed with removal of two to three gallons of straw colored fluid each time. The patient was told that he probably had a carcinoma of the liver; he refused intervention of any kind. Following this he limited his diet to soy beans, wheat, popcorn and bran, and his ascites and edema disappeared. This remission persisted for five or six years, until about one year prior to his hospital admission at which time he first noticed a mass in the middle of his epigastrium which gradually increased in size. This was associated with a feeling of fullness, especially after meals. Pedal edema recurred (8 months) and the abdomen gradually increased in size during the six months prior to admission. Increasing weakness and progressive weight loss were prominent symptoms during the last three months.

Past and Family History: Non-contributory except for a "sore on the penis" noticed shortly before the initial onset of ascites 12 years previously.

Physical Examination: Admission temperature was 98.8 F.; pulse 80 and respiration 18. There was a slight pallor of the mucous membranes and an icteric tint to the sclerae. The chest was not remarkable save

for a blowing systolic murmur which was heard best at the apex of the heart and transmitted to the axilla. Blood pressure was 118/68. The heart was not enlarged. There was a mass palpable in the epigastrium extending 10 cm. below the xiphoid process; it was firm, nodular and moved with respiration. The spleen was palpably enlarged (2 cm.). Numerous scars of previous paracenteses were present. There were bilateral inguinal herniae. Slight pitting edema was noted over the ankles. Lymph nodes of the right inguinal region and left cervical chain were enlarged.

Laboratory Data: On admission urinalysis was essentially negative. Hb. was 4.5 Gm. and erythrocytes numbered 2,930,000/cu. mm. There was marked anisocytosis, poikilocytosis, and moderate polychromatophilia. There were 8.4 per cent reticulocytes. White blood cells numbered 3,500/cu. mm. with 84 per cent neutrophils (3 per cent juveniles and 17 per cent stabs) and 16 per cent lymphocytes. Platelets numbered 222,680/cu. mm. Serum protein was 5.8 Gm. per cent. The icteric index was 4.5 with an indirect Van den Bergh reaction of 0.4 mg. per cent. On June 12, 1944, the urine contained four plus urobilinogen and gave a positive reaction for bilirubin. Serum bilirubin on June 14, 1944 was 0.5 mg. per cent. The Mazzini reaction was negative. On December 20, 1944 a cephalin-flocculation test gave a three plus reaction at 24 hours; it was four plus at 48 hours. On January 9, 1945 agglutinations were run against brucellosis; these were not positive in dilutions greater than 1 to 50. X-ray studies revealed a mass extrinsic to the stomach lying just above the lesser curvature. Gastric emptying time was not prolonged. The chest was negative.

Clinical Course: The patient showed essentially no change until January 5, 1945 when he had an attack of weakness, dizziness, and nausea. This persisted for three days with gradual improvement. On January 17, 1945 an exploratory laparotomy was done with removal of a wedge-shaped portion of liver. Blood transfusions were given the following day also intravenous crystalloids, aminophyllin and strychnine. On Janu-

ary 19, 1945 there was evidence of dullness of the posterior lobes of the lungs and the temperature rose to 102 degrees F. On January 20, 1945 the patient was definitely worse and there was slight cyanosis. His fever persisted. Venesection and digitalization were begun, but the patient failed to respond and died on this day.

MAJOR ISHMAEL: A major difficulty in evaluating this case is the confusing array of symptoms many of which, superficially, appear to bear no relationship to others. We shall select as a starting point one of the outstanding symptoms, or rather signs about which there is no question, that is the ascites which was first apparent 12 years before death and for which almost 100 abdominal paracenteses were done. Let us consider the various conditions which can result in ascites. These fall into only three major categories: one, peritonitis, not necessarily of an infectious nature, since diffuse neoplastic involvement, polyserositis or irritation of any sort may produce the same thing; second, portal hypertension on the basis of obstruction of the portal venous system from any of a wide variety of causes. Such obstruction may arise locally from pressure extrinsic to the vein as in the case of markedly enlarged lymph nodes at the porta hepatis or from any tumor mass in the immediate vicinity of the portal vein which compresses it. Thrombosis i. e. an obstruction from within can just as effectively produce obstruction and resultant ascites. Occasionally such obstruction occurs in the hepatic vein or even the inferior vena cava with ascites as a prominent effect. Most often the cause of prolonged persistent ascites such as we have in this case comes about from the obstruction of multiple tiny venules or the capillary bed of the portal venous system within the liver itself. It is obvious that obstruction at this level, if it involves most of the radicles, would be every bit as effective as occlusion of the portal vein itself. The usual cause of such obstruction is scarring throughout the triadal areas of the hepatic lobules as in the case of portal cirrhosis, also called as you remember laennec's, atrophic or alcoholic cirrhosis. Diffuse hepatitis may also produce ascites occasionally as does extensive tumor infiltration of the liver; in fact, any lesion which will cause the liver to swell to such an extent that venous or capillary channels are compressed (from the increased internal pressure) will produce ascites. By yet another primary mechanism, cardiac failure not infrequently produces ascites. Here the

portal hypertension is on the basis of a fluid barrier, i. e. increased hydrostatic pressure in the vena cavity initiated by a failure of the heart. Our third category of causes for ascites includes those conditions which produce a generalized effect on capillary endothelium all over the body e. g. nephritis or those conditions which although they do not increase the permeability of capillary endothelium yet profoundly alter the balance between vascular and tissue fluids. e. g. lipoid nephrosis or nutritional edema. In these latter conditions the protein content of the plasma is insufficient to exert the normal osmotic pressure. Especially in the case of nutritional edema fluid apt to accumulate in the peritoneal cavity.

The duration of symptoms in the case we are considering today and the association of other pertinent symptoms is sufficient to eliminate many of the possibilities which we have considered, e. g. nephritis, peritonitis of bacterial or neoplastic origin etc. Now this patient had jaundice and pedal edema in addition to his ascites. We learn too that he had a severe degree of anemia. Jaundice immediately suggests a primary lesion in the liver and implies that hepatic disease may have been the basis for the ascites. Hepatic insufficiency could also have been responsible for the anemia and hypoproteinemia. Let us consider for a moment the sequence in which the various signs and symptoms developed. If the ascites appeared before the pedal edema that would be rather against heart failure as the initiating cause and suggest an origin within the liver itself. The ascites was very much out of proportion to the edema elsewhere, a fact that also points rather definitely to portal hypertension as a primary cause rather than a secondary effort. The story of a progressively enlarging mass in the epigastrium presents several possibilities. I could well represent hepatic enlargement; this would correlate with jaundice and ascites on the basis of hepatic disease. On the other hand we have no definite evidence that this mass may not have been a malignant neoplasm of the stomach or pancreas etc.; the x-ray findings eliminate the stomach as the source of this mass. If we consider the epigastric tumor to be an enlarged liver what are the possibilities? With this prolonged history and an early transient episode of jaundice, the most likely diagnosis is portal cirrhosis. In using this term I wish also to include toxic cirrhosis, a condition which although of somewhat different pathogenesis is, in its end stage, indistinguishable clinically from that cirrhosis which is so fre-

quently associated with the excessive use of alcohol for many years. We can, with little difficulty eliminate biliary or, as it is sometimes called, infectious or obstructive cirrhosis since in this condition jaundice is the predominant sign and ascites if it occurs at all, is a terminal event. Syphilitic cirrhosis is unlikely but is remotely possible; we have here a pretty good history of syphilis of many years duration that was never treated; the negative serology is again syphilitic cirrhosis however. Other types of cirrhosis such as cardiac cirrhosis or the cirrhosis associated with hemochromatosis can be dismissed. In the case of the former, cardiac failure of years duration would be the dominant feature. In the case of hemochromatosis the duration of symptoms is too long, then too we would expect other signs or symptoms such as a bronzed discoloration of the skin, diabetes mellitus, etc.

A more careful evaluation of certain features of the laboratory data may have an important bearing on our diagnosis. The Van den Bergh reaction gives us little information; it is practically within normal limits. There was four plus urobilinogen in the urine and a positive reaction for bilirubin. The presence of these bile pigments indicates an abnormality in metabolism of biliary constituents which might be on the basis of (a) biliary obstruction, (b) hepatitis (including cirrhosis) or (c) increased destruction of erythrocytes. In biliary destruction urobilinogen is not increased to the extent that we see it here (with complete obstruction urobilinogen is not present in the urine at all), then too we are not dealing with a case of frank jaundice. On the other hand with excessive hemolysis there is urobilinogen but no bilirubin in the urine. The combination that we observe is compatible with hepatitis, either infectious or toxic, or cirrhosis. Hepatitis is obviously out of the question in view of the 12 year history. The reaction to the cephalin flocculation test is positive indication of extensive hepatic damage. Remember that about four-fifths of the liver must be out of action before any evidence of decreased function appears.

The pedal edema which the patient complained of upon several occasions was probably on a nutritional basis. We have positive evidence from our laboratory data that the patient was hypoproteinemic. There are three things which may have accounted for this: one, with hepatic damage protein synthesis is interfered with; two, the patient admitted dietary idiosyncrasies in which animal protein was excluded; three, a very important factor concerns the fact that upon 96 occasions from two to three gallons of

ascitic fluid was removed. Recall that in some instances the protein content of such fluid is so high that it is considered worthwhile to infuse it back into the patient. The severe anemia which the present can be explained in part on a somewhat similar basis; hepatic insufficiency interfered perhaps to some degree with storage and utilization of the erythrocyte maturing factor. This was not a major factor however because the patient's anemia was of the hypochromic type and the reticulocyte count was high (8.4 per cent). Nutritional deficiency must be considered at least partially responsible, and by this I do not mean solely the lack of iron; protein deficiency was probably a greater factor. Don't forget that it takes protein as well as iron to make hemoglobin not to mention the stromal portion of the red blood cell. Probably the most important cause of anemia here was a heightened activity of the spleen with resultant destruction of normal erythrocytes. This occasionally happens in conditions in which the spleen is unnaturally stimulated. This reaction in Banti's syndrome is well known. In this case splenomegaly was described as one of the physical findings and in addition to the anemia there was a leukopenia which could be explained on the same basis. If the anemia were on the basis of excessive activity it would actually be a hemolytic anemia and one would expect an increased reticulocyte count as was found in this case. There would also be evidence of altered metabolism of bile salts. This was observed here but its significance is obscured in the face of obvious hepatic damage.

CLINICAL DIAGNOSIS

My final diagnosis then is (1) Portal cirrhosis which accounts for the history of jaundice and ascites and for certain of the laboratory findings which were discussed (2) Hypoproteinemia which accounts for the pedal edema and, in part, for the ascites and anemia and (3) Excessive activity of the spleen accounting in major part for the anemia and for the leukopenia.

Question: Would you discuss the terminal events leading to deaths in this case?

MAJOR ISHMAEL: I should have mentioned this. The outstanding terminal event was quite clear I believe, hypostatic pneumonia. As you know, bronchopneumonia is the commonest direct cause of death in those that do not die quickly. There is one factor that deserves special mention in this case however and that is the protein malnutrition. Certainly this predisposes to be edema and by such action would favor the occurrence of hypostatic pneumonia. Furthermore, it has been demonstrated beyond question that with

hypoproteinemia there is a marked decrease in resistance to infectious disease. I believe that hypoproteinemia may be indicated as a major factor in causing the pneumonia that terminated this patient's life. You understand that he did have a fatal disease, unrelated to the pneumonia, and that he would probably have succumbed to his cirrhosis within a few years at the most.

Question: Does not the fact that this patient lived 12 years after first getting ascites suggest that the initial process was not portal cirrhosis but perhaps some inflammatory lesion of the liver which later lead to the development of cirrhosis?

MAJOR ISHMAEL: That is a very pertinent question. Certainly 12 years is a much longer period of time than patients with portal cirrhosis usually live once ascites become prominent. It is usually stated that in portal cirrhosis the average survival after abdominal paracentesis first becomes necessary is about two years. It may be that this patient did experience some acute process initially which accounted for that first period of jaundice and ascites, on the other hand recall that the initial period of ascites was of several years' duration, rather a long period of time for a transient acute process to exert its effect. It seems to me that a more logical explanation, strictly hypothetical in nature, is that by some means or another this patient, after the first few years of his cirrhosis, established some new collateral channels by which portal decompression was accomplished. Such a reaction could have come about from interabdominal adhesions providing essentially the same thing that the Talma Morrison operation is designed to do in cases of this sort. These new channels were sufficient then to bypass the partially sclerosed intra-hepatic venules and capillaries for the several years during which time the patient experienced his remission. The scarring of portal triads with disorganization of normal hepatic structure was relentlessly proceeding throughout this period however and finally the intra-hepatic vessels were obstructed to the extent that the collateral circulation once more became inadequate, thus once more ascites appeared. Another point to consider is that a goodly proportion of patients with portal cirrhosis die of hemorrhage following the rupture of an esophageal varix. This patient did not seem to have dangerous varices of this sort which perhaps allowed him to survive for longer than the usual time.

Question: With the cirrhosis, splenomegaly, anemia and leukopenia can you absolutely rule out Banti's syndrome?

MAJOR ISHMAEL: No, the history points rather definitely to an initial lesion in the

liver but late involvement of the spleen rather than the reverse which is supposed to be characteristic of Banti's syndrome.

DOCTOR BAYLEY: I saw this patient at a staff conference during his terminal illness and there was considerable discussion regarding the epigastric mass mentioned which seemed unquestionably to be his liver. It was large and it was hard but there was quite a nodule present just to the left of the midline. Reviewing the history of jaundice and ascites, we felt quite certain that he had cirrhosis at that time. When we saw him, however, he had little or no ascites and the liver was very easy to feel. It was definitely nodular to palpation. It is unusual for portal cirrhosis to present nodules which can be palpated through the abdominal wall. This large nodule on the left side was too large to fit the usual picture of portal cirrhosis and brought up the question as to whether or not something else had happened to the liver. It is possible that cirrhosis can develop gradually along with an ascites which accompanies hepatitis. The hepatitis may then subside gradually but the underlying proliferation of fibrous tissue, the cirrhosis, continues. In addition to an inflammatory origin the question of a malignant neoplasm was also considered. We did not consider syphilitic cirrhosis because this is almost invariably accompanied by a positive serology which this patient did not have. Our x-ray studies were primarily for the purpose of determining whether there was neoplastic involvement of the stomach. The stomach showed nothing, as you have seen, so that we were still left in doubt as to the exact nature of this large nodule on the left side of the liver. It seemed reasonably safe to exclude a cardiac factor as the cause of hepatic enlargement here because the spleen was also enlarged. Passive congestion of cardiac origin, although it will produce hepatomegaly of such a degree rarely produces a palpable spleen. The splenomegaly here points to portal hypertension from some local cause.

DOCTOR HOPPS: In regard to Dr. Bayley's comments about the size of hepatic nodules in cirrhosis it should be mentioned that the so-called toxic cirrhosis, identical with portal cirrhosis in its late effects, although of somewhat different pathogenesis is, according to Mallory, differentiated from the ordinary portal cirrhosis by the fact that the nodules are larger, up to three or four cm. It is this type of cirrhosis too which is most often ushered in by a transient episode of jaundice. With cirrhosis of this type hepatic nodules might be readily discernible through the abdominal wall. Of course this would not explain the large nodule Dr. Bayley de-

scribed in the left lobe of the liver. Nodularity of this degree would in itself be adequate to rule out cardiac cirrhosis because in this latter condition the liver is finely granular.

ANATOMICAL DIAGNOSIS

DOCTOR HALPERT: We have a considerable number of questions to answer from our necropsy findings although the major disease, portal cirrhosis, seems pretty well agreed upon. First let us consider the liver and changes related to its alteration. The liver presented a characteristic appearance of portal cirrhosis. It was firm, of increased density and diffusely nodular, the nodules being of variable sizes from 0.1 of slightly over 1 cm. in diameter. Although one might have expected gross atrophy at this stage, the liver weighed 1600 gm. which is normal for this patient. One of the striking changes and one which accounts for the mystery of the large nodule just to the left of the midline within the substance of the liver was a peculiar alteration in the shape of the liver; the right lobe was approximately half the normal size, whereas the left lobe was two or three times the normal size. It was this peculiarity of form which gave the impression of a large mass just to the left of the midline. Actually it was the abnormally large left lobe which was palpated: only 350 cc. of fluid was present. Almost this much was contained in each of the pleural cavities and there was an excess of fluid also in the pericardial sac. This, I believe, confirms Major Ishmael's impression that hypoproteinemia was a major factor in the edema which this patient exhibited. The azygos veins and veins of the lower esophagus were markedly distended. There was no esophageal erosion nor evidence of hemorrhage into the intestinal tract however. As an additional feature of the portal hypertension produced by this cirrhosis, the spleen was enlarged about three times: it weighed 675 gm. It was dark red and firm, characteristic of chronic passive congestion. Other abdominal organs exhibited minor changes only. The heart presented an essentially normal weight and appearance so that we can eliminate cardiac failure as an element in the hepatic or splenic enlargement or in the edema which this patient manifested. The cardiac murmur, in view of these findings was probably of hemic origin. The patient did, you recall, have a profound anemia. The lungs provide an answer to the question what was the immediate cause of death. Together they weighed 2700 gm., four times the normal. They were essentially similar, mottled grey red, dense, boggy and markedly subcrepitant particularly in their dependent portions. In fact the only portions which

contained appreciable air were the anterior margins and perhaps one half of the upper lobes. The trachea and bronchi were reddened and their mucosa was slightly granular; all in all the appearance was typical of marked hypostatic bronchopneumonia. So much for the pathologic findings which, incidentally were all confirmed by microscopic study. There remain yet several points for explanation. Why did this man after an initial episode of ascites which lasted several years and necessitated 96 abdominal paracenteses, rather abruptly go into a prolonged period of remission, a period in which he was essentially free from symptoms for several years? Major Ishmael advanced an attractive hypothesis when he spoke of the development of adhesions which for a time provide sufficient collateral circulation to decompress the portal venous system. Unfortunately we were not able to demonstrate such adhesions at necropsy. I spoke before of the peculiar configuration of this patient's liver. This might have been on the basis of a congenital anomaly. It is more likely however, that the marked disproportion of the left lobe resulted from an extensive proliferation of the hepatic cells there, a proliferation that entailed a re-establishment to some degree of the venous channels which provide passageway for portal blood to reach the inferior vena cava. As the cirrhotic process continued with progressively more scarring and alteration of architecture, this temporary effect was nullified and thus ended the period of remission. As to the pathogenesis of the cirrhosis in this case, it is always difficult when looking at the end stage of a disease, and end stage which, in this instance, took twelve years to develop, to determine the exact mechanism of initial injury. We can say definitely that syphilis was not the cause and we can readily rule out chronic heart failure, hemochromatosis, biliary obstruction of chronic infection of the bile ducts. As has been stated, this patient had portal cirrhosis. The present concept of this disease is that it arises on the basis of repeated injuries, chemical in nature, originating from the intestinal tract and passing to the liver by way of the portal circulation. Recently it has been determined experimentally that such injury is much more prone to result in cirrhosis if the affected individual is deficient in protein or certain members of the B complex of vitamins. Perhaps this deficiency interferes with the normal capacity of hepatic cells to regenerate. At any rate we know that following such injury a portion of the hepatic cells are killed whereas the more resistant connective tissue survives. In fact the same injury which destroys the parenchymal cells

may actually serve to stimulate proliferation of fibrous tissue. Those liver cells which persist then multiply in an irregular fashion. This together with the abnormal proliferation of connective tissue establishes the de-arrangement of architecture which is so characteristic of portal cirrhosis. Such is the effect of multiple injuries, repeated many times over a period of years until the disease is finally established. Dr. Hopps mentioned another mechanism in which following a very extensive single injury cirrhosis of this same general type develops so called toxic cirrhosis. The injury in such a case is usually diffuse toxic necrosis which in itself is often fatal. Of the survivors, a portion, in the course of the next few years develop cirrhosis. It was mentioned that cirrhosis of this type is often characterized by much coarser nodules in the liver. Such was not the case here and, although there was an initial period of jaundice, there was no history of an initial illness which would suggest diffuse toxic necrosis (acute yellow atrophy).

In Death

The following inscription found on a violin should cause us to ponder the timber of living.

"In life I was a part of the woods
In death I sing like the wind."

The Importance of Pathology

I wish I could impress upon every young member of our profession the importance of pathology, for it is the foundation of a successful career and practice. A true conception of this subject combines the laboratory with the post-mortem-room. As I look back now I realize that practically every active member of this society at the time of which I write was then or became later famous in medicine. There was E. G. Janeway (I nicknamed him "ejus generis"), the indefatigable worker, close observer, conscientiously studying his cases, and, when death occurred, reaping the full benefit of his successes or failures in diagnosis and treatment by a minute examination of the organs involved. He became one of the greatest diagnosticians in medicine the profession has ever known. To every beginner in medicine asking, "How may I succeed?" I would say, "Study the career of Edward G. Janeway and try to follow it."—*John Allan Wyeth. With Sabre and Scalpel. p. 378. 1924.*

The Value of Medical Science

The value of medical science depends wholly upon its connection with medical art. It might, to be sure, be cultivated, as an interesting subject of inquiry, independent of this connection; but it derives most of its interest, and all of its importance, and practical utility, from its agency in the prevention, mitigation, and removal of disease. These are its great ends and objects, and so far, only, as it attains them, or ministers to them, can it lay claim to our veneration and regard, as a blessing and a benefit to our race.—*Elisha Bartlett. An Inquiry into the Degree of Certainty in Medicine. 1948.*

ANNOUNCING THE FIFTEENTH ANNUAL CONFERENCE OF THE OKLAHOMA CITY CLINICAL SOCIETY NOVEMBER 26, 27, 28, 29, 1945.

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SPECIAL ARTICLE

WAR PSYCHOLOGY AND POSTWAR PERSPECTIVE

LEWIS J. MOORMAN, M.D.
OKLAHOMA CITY, OKLAHOMA

No one can go to war under modern conditions and come out of the conflict without experiencing profound psychological changes. But the fact that we have passed from the Javelin to the Atomic bomb and that we can discuss the latter's grave potentialities with a strange mental calm indicates the quality of our National psychology and our ability to take what comes. Our batting average should be relatively good if we encourage our boys to stand up and strike.

On the promise that the life of the normal individual is made up of idealism and realism in a flexible compensating blend, we are of the opinion that many of our soldiers returning from the war with psychological conflicts may be able to strike a happy balance through latent powers temporarily buried in their distraught souls. At least they should be given the opportunity to adjust themselves to their postwar environment before they are classified and pensioned. With civilian liberty, loved ones, friends, a job, and home there is hope. They may yet be the captain of their souls.

Walter Pagel¹ says: "We may disentangle individual phenomena or problems of Life and discuss them, but Life itself beats the human intellect." Allowing for certain exceptions, the report that General Eisenhower hopes that the men coming home will not be psychoanalyzed is in line with sound sense.

Bauer² says: "It seems to me that more stress should be laid upon re-education of a patient, on psychosyntheses rather than psychoanalysis, on readjusting him for the future rather than on digging into his past. It is the striving more than the achievement which makes a man happy and makes him fit."

The therapeutic advantage of striving and the hope of achievement may be wholly annulled by a high sounding diagnosis and a comfortable allowance. Even though a spark of ambition remains or a forlorn hope arises, a neuropsychiatric sentence is hard to live down.

For fear of a misunderstanding, we hasten to say that in war as in civilian life the

sooner genuine psychiatric casualties are recognized and treated, the better. On the other hand the men who normally met the problems of civilian life before they went to war should be carefully separated from those who were not carrying on successfully before they were accepted for service. At least the former group should have a chance to beat back even though the terrific impact of war has temporarily changed their psychological pattern. Let us hope that civilian pursuits will serve as a solvent in such cases. Many writers in this field think this course better than bureaucratic control.

The government faces a stupendous task fraught with a heavy responsibility.

Terhune³ says: "This problem is too big for the government to handle. . . . If the government tries to care for these patients, after discharge from the Army . . . results will be unsatisfactory. The practice of medicine is based on an individual relationship existing between doctor and patient — this necessary personal emotional transference cannot exist between a government bureau and patient. Therefore, it will be the job of civilian physicians, who know these men and are familiar with the facilities of the communities in which they live, to readjust them to civilian life."

Much has been said about the need of more trained psychiatrists to care for these war casualties, but a level gaze at the over-all problem makes it equally obvious that we need plenty of good doctors, skilled in both the science and the art of medicine, to at least help the borderline cases get back to normal life with satisfactory adjustments. In this way many may escape hopeless invalidism and dependency.

Williams⁴ says: "If there exists, as part of man's response to his environment, a normal emotional reaction, — and outside of the psychiatrist's world, at least, it does exist, — then many of the fear and anxiety reactions engendered and precipitated by the indescribable conditions in combat zones cannot justifiably be labeled 'psychoneurotic'."

Williams⁴ quotes the following from Thomas⁵ thus stressing the injuries of hasty

diagnosis and classification:

"They constitute a behavior pattern that has been witnessed in armies throughout the ages. Until the advent of modern psychiatry, such conduct was attributed to a variation in men's capacity to sever themselves from their usual way of life and to conquer a fear of impending death. The will to fight, morale, training, fatigue, disheartening reverses and leadership were recognized as factors able to influence a man's emotions. These factors are acknowledged in this war, but the frequency with which the diagnosis of a psychoneurosis is made raises a suspicion that psychiatrists have encouraged a shrouding of them in an ill use of terminology. In doing so they have thrown the problem of psychoneurosis out of focus with what seems to be the facts. . . . There are psychiatrists who regard the familiar fear of a soldier in a dangerous situation as a measure of the emotion of an anxiety neurosis. This is tantamount to calling all frightened and bewildered soldiers psychoneurotic. . . . Careless use of the term 'anxiety' does injustice of the Army, the soldier, and the taxpayer."

Both the Army and the Navy have instituted rehabilitation programs — with group therapy as a method of choice. It is to be hoped that in many cases such therapy may be found sufficiently adequate to enable them to escape both civilian and veterans administration care and the embarrassment and handicaps which either might entail. Considering the veterans administration care, we again quote Williams¹:

"One of the most important elements in this situation is the matter of compensation or pensions for veterans. Unfortunately, many men will accept government aid as long as it may be forthcoming, and thus neurotic reactions will become fixed either for life or for years."

In this connection we turn to Sinclair⁶ of the Australian Army Medical Corps:

"The nation is still paying for the neuroses directly or indirectly attributable to the last war. The burden following the present conflict will be far greater. The policy adopted after the last war was to pension the soldier and to treat him at a repatriation centre. It will be a great pity if we repeat that folly. There seems no doubt that to shackle the neurotic to his symptoms and disabilities by a monetary dole is a poor solution to his problems. . . . Society will best support the neurotic repatriated soldier by giving him constructive, creative and sympathetic service, rather than by paying him a fortnightly pension in an endeavor to forget him."

As a final indication of what we are facing and the urgent need of popular education on

things medical, we return to Terhune³ who makes this significant statement:

"The greatest hazard that exists in treating ex-servicemen who are psychoneurotic is that they are eligible for federal pensions. Once these men have applied for a pension or have secured one, it becomes practically impossible to cure them. Few compensation neuroses recover as long as the compensation continues in effect. It is unfortunate that recent federal legislation makes these patients eligible for pensions, since this very fact will make many confirmed neurotics of individuals who would otherwise recover. Such federal provision was made without consultation with medical authorities familiar with the problem."

The following from Readjustment to Civilian Jobs prepared by the sub committee on psychiatry of the National Association of Manufacturers Medical Advisory Committee, is most significant:

"The problem of the neuropsychiatric has, of course, been greater because of the war. In fact, during the last few years, the NP (neuropsychiatric) cases have been an old story for, in scraping the bottom of the labor barrel, industry has been hiring not only those men rejected at the induction lines, and classified as 4-F simply because it was felt that they could not adjust to some of the requirements of the armed services, but also many thousands of discharges from mental hospitals and other thousands with histories of serious emotional and nervous conditions. These people do not, however, constitute a risk in civilian society. Many are extremely valuable employees, as a matter of fact, most of us have some history of a minor or major nervous or mental condition."

In keeping with our plea for a fair trial is the following from the same pamphlet:

"This process of readjustment for peace (involving the return of the enthusiasm and incentive generally part of peacetime life, which for purpose of definition is often termed re-indoctrination and re-incentivation) appears to be brief and comparatively simple with some, and more extended and difficult with others. This period is often characterized by a high degree of restlessness, with an increased 'grousing' tendency that has no deep feeling behind it, and often with a transitory change in the character of the individual such as increased irritability, supercilious attitudes, seeming indifference and other traits indicating a lack of the usual sustained and normal interest in occupation. However, these symptoms tend to disappear spontaneously as the individual's war experience recedes in point of time."

After a warning against exaggeration of

neuropsychiatric problems by the interviewer, we find this statement:

"It is the belief of this committee that, in general, exhaustive psychiatric examinations are unwarranted as well as unwise for the mass of applicants, but that some assistance from psychiatrically-trained personnel may facilitate the better placement of some applicants, and may prove essential in the handling of a certain few applicants. On the other hand, where such assistance is not available, some psychiatric principles, when understood by the average non-psychiatric industrial physician or lay person in charge of employment, might well serve a very useful purpose."

With the evidence before us, what are we

going to do about it? In behalf of the returning serviceman and the taxpayer, should we not petition Congress to change the laws and to view the problem through the doctor's eyes as a matter of national welfare

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FORUM

This timely editorial¹ by Henshaw* and Feldman will bring our readers up to date on this important subject.

CHEMOTHERAPY OF TUBERCULOSIS

Several sulfonamide compounds possess slight bacteriostatic activity against the bacillus of tuberculosis but in no instance has this been sufficiently marked to foster hopes of clinical application. Drugs of the sulfone series (promin, diasone) are active against experimental tuberculosis of guinea pigs but the toxic potentialities of available drugs in this group restrict their use for human beings to topical application in treatment of superficial lesions of tuberculosis. Although promin in a jelly vehicle recently has been approved for distribution by the Federal Drugs Administration, no fully convincing evidence of its therapeutic efficacy has been submitted as yet. Promin also has been released for parenteral administration in treatment of leprosy and this solution has been utilized in nebulized spray for treatment of tracheobronchial tuberculosis, but not in a sufficient number of cases to prove its effectiveness.

A third group of interesting compounds (heterocyclic sulfones) is represented by promizole, which is effective in treatment of experimental tuberculosis of guinea pigs, but clinical trials so far have revealed inadequate evidence of therapeutic efficacy. Promizole, when given orally, is distinctly less toxic to the human being than are the diphenyl sulfone compounds, such as promin and diasone.

Several antibiotic substances have been described in the past twenty-five years which are effective against Mycobacterium tuberculosis in test-tube experiments. Only one of these has as yet demonstrated an ability to arrest the progress of tuberculosis experimentally induced in guinea pigs. This substance is derived from cultures of a soil-inhabiting fungus and is called "streptomycin." It is highly effective in treatment of experimentally infected guinea pigs but previous disappointments with other substances should temper any enthusiastic predictions as to clinical applications of this drug in tuberculosis. Streptomycin is difficult and expensive to produce and the extreme scarcity of the material will be a restraining influence on clinical studies for many months to come.

Many forms of tuberculosis in man tend to improve spontaneously and this fact must constantly influence judgment of apparent chemotherapeutic effects. The granulomatous tissue responses to chronic tuberculosis infection may offer a serious obstacle to penetration of bacteriostatic substances. Most antibacterial agents are not bactericidal but act by restraining multiplication of the pathogens. Hence the rapidity of the patients' recovery will depend on natural reparative mechanisms, which are slow in tuberculosis. The probable longevity of tubercle bacilli may also be a deterrent factor to rapid healing of lesions, even in the presence of an adequate concentration of a bacteriostatic agent. Despite these theoretic handicaps it must be emphasized that steady progress has been maintained in the search for an effective

1. H. Corwin Hinshaw, M.D.; William H. Feldman, M.D. Minnesota Medicine, Vol. 28, No. 8, pp. 661-662, August, 1945.

*H. Corwin Hinshaw is Chairman of the American Trudeau Society Committee on Therapy.

tive and safe chemotherapeutic or antibiotic agent in tuberculosis.

The beneficial effect of rest therapy, usually in the planned environment of a sanatorium, and the corrective collapse measures which remove mechanical handicaps to healing are thoroughly established as effective remedies in treatment of tuberculosis. No patient should refuse or postpone acceptance of these measures because of unreliable rumors of the imminent availability of a chemotherapeutic drug or antibiotic agent.

Patients are frequently very eager to receive experimental drugs, even when hope of benefit appears to be remote. Usually it is impossible to receive such drugs under these circumstances because of legal restrictions which have been imposed in recent years. These laws are designed to prevent unwise distribution of drugs whose safety may not have been determined and also serve to conserve rare and valuable drugs for essential research purposes. Investigators receiving experimental drugs may not share their supplies with other physicians and manufacturers must restrict distribution of such drugs to research institutions.

When the requirements of the present war have been met, it is ardently hoped that materials and talent will be diverted to research which may lead to improved methods of treating tuberculosis. This disease claims more lives than war, is similarly crippling and also selects its victims from the most productive age groups of the human race. No expenditure of effort, however great or productive age groups of the human race. tributes toward the eventual conquest of the great white plague.

EDITORIALLY SPEAKING*

Dear President Truman:

Everyone in Jackson County and in the State of Missouri is bursting his buttons with pride over your outstanding performance as our new President; even pre-election detractors and mudslingers are yelling "Uncle", and that's something!

Perhaps in your lofty position you sensed the thrill of gratification which swept our entire Country, clear back in the out-of-the-way places, when you took office. We all know your predecessor achieved a rare niche in our Nation's annals. Yet it is no disparagement to say that since the Divine Power chose to place you in your present position, the Country feels secure knowing that good, solid, American ideals and traditions will be preserved.

Among changes which have been and are

being proposed in our American way of life are those dealing with the medical care of people. There has been an ever-increasing consciousness on the part of the public (principally stimulated by welfare workers) that changes in the manner of medical care are due, or perhaps are overdue.

With him who says, "The American people deserve the best medical care in the world," every average American physician hastens to lend his full assent and support. With him who says, "Why not ape the British or German systems of state-controlled medical care?" — most thinking American physicians disagree. We know best the difference between a glorified office-boy with a medical degree, who goes through the motions of taking care of a person, and the physician whose entire future depends on personal and satisfactory service of such a high standard that the patient wants to come back.

Mr. President, all persons licensed to practice medicine and surgery or law, or theology (for that matter) have not the same, equally-good qualifications. For instance, every bearer of a diploma of law is not permitted to argue cases before our Supreme Court; one might call this "restraint of trade." Similarly, every licensed physician is not equally qualified — as only fellow-practitioners know too well — to carry out all phases of medical practice with complete equity and fairness to the public.

As a consequence of some past abuses in medical-school training and in hospital practices, we find today virtually only class-A medical schools existing in America, and the hospital techniques of caring for patients have been improved immeasurably. The overall standards of medical care in our United States have risen to a peak never before known on the face of the earth! All these accomplishments have been done slowly by voluntary methods, and *have not been imposed by government*, either on a national scale or by political subdivisions thereof. *Still we American physicians are not satisfied. We want to do better, for we know a better job can be done; and, if we are given the chance, we will do it!*

Our record proves: we would like the stimulating competition of more well-qualified physicians throughout our country; we would be happy if every man, woman and child could have pre-paid insurance covering medical and hospital bills; we would welcome more hospital and diagnostic units (wherever a locality needs one) if these are adequately staffed; we will cooperate eagerly with any system which helps stamp out tuberculosis, heart disease, cancer or any other

*Vincent Williams, M.D., Jackson County Medical Society Weekly Bulletin, Kansas City, Missouri. July 14, 1945.

diseases; we will do our utmost to see that the returned veteran, the industrial worker, and the average person receive the best medical care in the world. We, the physicians of America, pledge and reaffirm you these things, Mr. President!

But when someone comes along and quotes figures and statistics or distorts the truth trying to prove that either the British panel-system of medicine, or the German, Bismarckian system is better than ours — we rebel! In Britain and in Germany, the people are treated as numbers on a list; they are not and can not be regarded under any such system with the same respect for individual human dignity as even the poorest of our citizens receive. The time was, when American physicians were forced to visit Europe before their medical education was considered complete, now the foreigners would like to come over here. Times have changed.

The successes of our medical comrades in the Armed Forces stem from those average physicians who now serve the wounded at the front, not from any governmental, bureaucratic system which was extant prior to their entrance into our Country's ranks. This same spirit will prevail when they return to improved medical conditions which we are developing, particularly after they see regimented medicine as it works in Europe!

Those of our profession who face facts realistically are quite aware of the inequitable distribution of medical care, of the crushing costs in certain medical situations, of the number of remedial physical defects which are not corrected, and of all the other imperfections in the present medical system. We know there are areas deplorably understaffed; we know of isolated cases wherein financial catastrophe resulted from prolonged illnesses; we are familiar with the rantings of skilled propagandists citing the experiences of Selective Service and high-lighting the alleged derelictions of the medical profession, as reflected by the number of rejected youth. Yet this apparently imposing mass of evidence against our profession melts when analyzed critically.

We — as a profession — have no right to force doctors into areas wherein even the farmers can scarcely raise their food; yet, with aid, this problem can be solved. The health of a nation depends not only on curing disease but, better still, on its prevention. In this connection, education, proper food, adequate clothing and housing, and many other factors enter the picture entirely outside the domain of physicians, except advisory, yet intimately associated with health and sickness! Doctors have never had police-

power to force corrective operations on the occupants of every little red school-house (even if offered gratis), yet, because our youth showed up for Selective Service with herniae, with eye defects, with bad teeth, with venereal disease or with nutritional disease (judged by the world's highest military standards) all this is blamed on the medical profession! How unfair this criticism seems when hundreds of thousands of illiterates were rejected by Selective Service, despite the fact that for many years we have had *free* schools and the *police-power to force education*.

This has been a rambling letter, Mr. President, for which we apologize. And yet with all humility, we of the medical profession *petition* you to use that native, solid, Missouri horse-sense, of which we are proud, in analyzing this situation. Medically speaking, we believe that to make every American citizen drive on the left-hand side of the street, or to adopt the German goose-step will not solve the medical needs of America.

Your own Jackson County's physicians and those of your own State of Missouri are not asleep. Yes, somebody must "show me," but once we are "showed," we go places! We are enclosing statistics, Mr. President, on the medical and hospital conditions in Missouri and throughout the United States, together with information on the growth of medical care and hospital plans. These data would be dry substance indeed if they were mere numbers — but they are not. They represent American men, women and children who are protected against the unpredictables of health. Free to choose their own physician, free to change to another if they so desire, and free to enter the hospital of their choice — altogether, *a saga of medical freedom as only America today knows it*. Witness the Missouri Medical Plan wherein the expenses of major medical, surgical and obstetrical care and hospital services are assured our citizens; witness the phenomenal growth of Blue Cross and of the other allied, hospital-care plans throughout our Nation.

True, no one blanket of government legerdemain has descended on our people at one fell swoop so that patients could swamp every physician with fancied pains and aches, merely because such service is free of charge. True, these voluntary plans have grown slowly, but consistently and inexorably, in contrast to some wholesale, legislative fiat. True, these voluntary efforts have made mistakes, they have slipped and they have fallen only to rise again stronger for the skinned shins and the bloody noses, much as a child must learn to walk—his papa can't do it for him even with billions of dollars!

We all remember that noble, but sad, tragic experiment called Prohibition, Mr. President. That was another example of perfect law-making, yet it didn't work, here in America.

Again, may we physicians of Jackson County and of Missouri salute you, Mr. President. We, in common with physicians all over our Country, are trying sincerely to improve medical care for our people in a way which is evolutionary, not revolutionary. Count on us to do our utmost in evolving a system which we can prove will be better for our citizenry; call on us for consultation in medical matters; we will give you the straight dope as best we can. *We stand ready to back you up in any medical system best for our entire Country.*

America has out-produced the world for this war; her men have rated among the highest as warriors. We Missouri physicians are confident and determined that American Medicine shall maintain the best in the world for our people, not by borrowed, old-world ideas — but by plain workable American methods!

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THE PRESIDENT'S PAGE

Our Executive Secretary will be back on duty before this page is printed and his ability to accomplish mass problems will again be demonstrated. One of the problems under consideration at the present time is that of visual education. This medium, which is to be presented in minute to three minute trailers, is well on its way to becoming a reality and is receiving strong support from all who are acquainted with the program. Through the help of the Cancer Committee, the Tuberculosis Committee, the State Board of Health and the Oklahoma State Medical Association, the medical profession, should be able to give to the people, in an entertaining way valuable health education having to do with the prevention and cure of disease.

When we realize that weekly 90,000,000 people attend moving picture shows in search of relaxation and entertainment, the unobtrusive snapshot trailers may carry valuable messages in an effective way. It is a great opportunity for the dissemination of health education.

It is a proven fact that this form of education was used most effectively in the Armed Forces. Visual education was the most effective means of teaching the soldier the manner in which he could accomplish his given task.

We feel that it is necessary that every effort be put forth to bring into being this form of health education at the earliest possible moment in order to further the health of the people in the state.



President.

SECOND IN A SERIES OF CHALLENGES TO MEDICINE'S

Achievements For Tomorrow

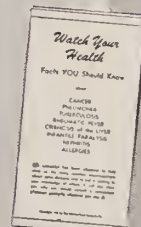
• **CANCER** killed 163,000 people in the United States during 1942, it is estimated*, and ranks second in causes of deaths. The rate apparently is increasing. About 300,000 new cases are diagnosed for the first time each year and approximately 475,000 persons are under treatment at any given time.

Many cancer patients can be cured by surgery, X-ray or radium if the disease is diagnosed early enough. There is not, however, sufficient information about the cause of cancer and its characteristics to have led to the discovery of a specific and generally applicable cure. Physicians are helping by reporting their experiences and observations. What will be the cure? Who will discover it?

People should be educated to the necessity of having examinations at the first symptoms indicative of cancer so that such curative measures as are available may be utilized as quickly as possible. Too many hide their condition until a cure is impossible.

To aid in such educational work, we have prepared a pamphlet — "Watch Your Health" — in which simple facts about this and six other serious diseases are given. Copies for distribution to your patients are available on request.

*U. S. Summary of Vital Statistics, 1942



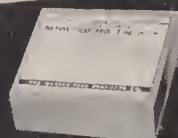
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EDITORIALS

ALL HONORS TO RETURNING MEDICS

At War's end we say with James Whitcomb Riley, "Why not idolize the doctor some?" The true story of what our men in the medical corps of the Army and Navy have accomplished is well told in *Doctors at War*.¹ Every doctor should read that well authenticated story and be proud of the scientific record. This formal record was prepared by doctors and scientists. There is a scattered but significant record which shows that the art of medicine marched to war with the science of medicine to give it the saving sense of sympathy and the mellow touch of mercy though often camouflaged by stern command.

Those who doubt should read the best books about the war, the close-up stories by combat men familiar with the front lines and first aid stations where civilian doctors in uniform, relatively free from red-tape attend the sick and wounded according to medicine's best traditions.

In these columns we have discussed Ernie Pyle's² fine tribute to the medics in *Brave Men*. We now turn to Bill Mauldin's³ *Up Front*. He goes so far as to say, "The medical corps has probably done more to endear

our army to civilians in stricken areas of Europe than the high-powered agencies which came over with that task in mind."

After a poignant story of his visit to an aid station in Italy in which he graphically portrays rugged medicine with a gentle touch and humane generosity, he closes with these lines:

"I felt good when I got back to a building in the rear end, and though I had hardly stuck my nose out from the protection of the aid station sandbags, I felt I had learned something. I sketched sixteen cartoon ideas in three hours.

"I came back to Rome, so I could send the book off and finish the sixteen drawings. I read the thing over before I took a bath, and darned if I didn't like it pretty well, even though it may be full of bad grammar. Now I've had the bath and the sixteen drawings are almost finished, and somehow I miss the aid station. It was pretty safe under the cliff, and it was warm and we were able to make coffee. It was full of homesick, tired men who were doing the job they were put there to do, and who had the guts and humaneness to kid around and try to make life easier for the other guy.

"They are big men and honest men, with the inner warmth that comes from the generosity and simplicity you learn up there. Until the doc can go back to his chrome office and gallstones and the dog face can go back to his farm and I can get back to my wife and son, that is the closest to home we can ever get."

To prove our tradition, we call up old *Doc Sifers of the Civil War*¹:

"Doc's own war-rickord wuzn't won so much in line o' fight

"As line o' work and nussin' done the wounded, day and night.

"His wuz the hand, through dark and dawn, 'at bound their wownds, and laid

"As soft as their own mother's on their forreds when they prayed. . . ."

With proud hearts we greet the medics returning. With bowed head we salute the dead, knowing they are more truly alive than we are.

1. *Doctors at War*. Edited by Morris Fishbein. Dutton & Co. New York. 1945.

2. *Brave Men*. Ernie Pyle. Henry Holt & Co. New York. 1944.

3. *Bill Mauldin*. Up Front., pp. 69, 226, 227, 227. Henry Holt & Co. New York. 1945.

4. *The Works of James Whitcomb Riley*. Rubaiyat of Doc Sifers and Home folks, pp. 37, 38. Charles Scribner's Sons. New York. 1910.

MEDICAL AND SOCIAL LEGISLATION

It has been said that knowledge is power, but this statement has been questioned by those who prefer to believe that judgment is power. Unfortunately, thinking people have reason to believe that in political circles the most powerful power, on certain occasions, may be wholly devoid of both knowledge and judgment. Congressional action on social and medical legislation without sound medical advice will place the lawmaker in the above embarrassing position. Good judgment is an indispensable quality, based upon knowledge. No matter how well educated a Congressman may be, he cannot exercise good judgment on things medical without a medical education, unless he follows the advice of doctors qualified to speak with authority. Attempts to make good legislative guesses may prove to be very dangerous, very expensive and may lead to irreparable damage.

The people in the United States, many of them clamoring for a change because of false propaganda with reference to medical care, do not know that the average Congressman does not have sufficient medical knowledge to admit him to the freshman year in a good medical school. In the field of medicine, Alexander Pope's line "A little learning is a dangerous thing," finds its most fitting application. Sad to say, many of those who stand ready to agree with Pope are not in a position to determine just what constitutes "a little learning" in medicine. What the common people need for their pro-

tection is a better understanding of what medicine, as a free enterprise, means to them. Once supplied with this information, they would keep their present brand of medical service under lock and key. Again, only doctors can adequately convey this knowledge.

Even a degree in Law seems not to enable some legislators to see that the support of regimented medicine violates the oath they took when they were licensed to practice law. In other words, they fail to support the Constitution designed to safeguard the sovereign rights of the individual. In behalf of the people, the members of the medical profession plead for the exercise of good judgment in medical and social legislation.

GOOD MEDICAL PUBLICITY

In the September issue of the *Atlantic Monthly*, Dr. John S. Fulton,¹ Physiologist, Medical Historian, in the chair of Physiology at Yale since 1932, gives the fascinating story of penicillin and the romance of blood plasma fractionation. Unfortunately, the *Atlantic Monthly* reaches a very small fraction of the common people. This intriguing story of vital interest to the people as well as the doctors, is brought within the comprehension of the average reader through Dr. Fulton's artful presentation.

Aside from its value as a medium through which the public may learn of certain scientific developments and their importance in the treatment of disease, it discusses in a comprehensive way, the fine medical and surgical record in World War II, naming the various contributing factors which have resulted in the lowest mortality achieved in the long history of human warfare. The author points out that not only chemotherapy and blood plasma but improved medical education and better trained young doctors have ranked among the important factors. Finally, after discussing the latter, he says, "We should reflect long and seriously on this point because our military forces, the Army in particular, have unwittingly done everything conceivable — and continue in this ill-timed policy — to lower the standards of medical education in this country and to hinder adequate training of pre-medical students. Moreover, through the accelerated teaching schedule on which they have sternly insisted, the Medical Departments of the Army and Navy have thrown to the four winds nearly everything that we had learned about medical education in the past fifty years. They have ignored our standards and requirements so completely that the medical schools of this country are now in the unenviable position of being unable to select their students on the basis of merit. Because of the con-

tinued refusal of the Congress, Selective Service and the Secretary of War to defer students preparing for the profession, there are virtually no physically fit male applicants from whom to select."

In closing with a discussion of medical research, the author says, "We shall show our wisdom in the ways and means chosen for the support of our post-war medical research. We must decide whether it is to be placed in the hands of bureaucratic Federal agencies that will be subject to political influence, or whether it will be set up under the supervision of recognized scientific bodies which are independent of political control."

It would be a bit of great good fortune if every doctor in Oklahoma could read this article and if it could be placed in the hands of every citizen who reads and thinks.

1. Fulton, John S.: Penicillin and the Romance of Blood Plasma Fractionation. *The Atlantic Monthly*. Aug. 1945.

A NEW HOPE FOR DISABLED VETERANS

The late unpleasant publicity about shocking inefficiency in the management of World War I veterans suffering from tuberculosis in Veteran Administration Facilities, while justified in many respects, was lacking in documentary evidence and contained some gross exaggerations. On the other hand, the people should have been given the facts long ago. More than twenty years unwarranted spread of disease, dissipation of hope, and waste of life might have been avoided if the "hot coals" had been heaped upon the head of General Hines early in the course of his career. If this had been done disabled veterans and the taxpayers would have had a better chance of receiving what they had a right to expect in the way of service.

Medicine in the hands of the lawmakers and lay administrators is subject to many serious hazards. Unfortunately, such hazards usually arise through a lack of knowledge rather than a lack of interest in the patient's welfare. It has been said that General Hines maintained a high congressional rating as an administrator, because he made it his business to turn back annually a part of his appropriation. Even though the members of Congress had undertaken the task of checking the returns on the many millions actually spent, without medical knowledge the truth might not have dawned upon them.

New hope comes through General Bradleys' sound medical policy as expressed by General Paul R. Hawley, designated as Surgeon General of the Veterans Administration medical service. The writer recently had the privilege of meeting General Hawley and hearing him outline his general plan and the sound purposes of the same, before an inter-

ested Committee Meeting in Washington with the hope of bringing about better care for ex-servicemen suffering from tuberculosis.

General Hawley's earnest, straight-forward presentation of his proposed program was in line with the best medical traditions and modern scientific medical service, education and training, including a consideration of the requirements of the recognized American Specialty Boards and the location of proposed hospitals near or in medical centers. The latter with a view of making available medical school facilities for educational and consultation purposes. In addition, General Hawley indicated a more generous policy with reference to remuneration for medical services and a more liberal allowance of time and money for graduate education, so limited for Veterans Administration medical staff personnel in the past. General Hawley's policy of seeking suggestions and advice from various medical groups and representatives of the various specialties is most hopeful.

Such policies on the part of the Surgeon General of this service with the full approval of General Bradley must necessarily result in better care of the Disabled Veteran. Since we must have Government care for our disabled soldiers, it is heartening to have the above statement of policies and the assurance that much of the paper work will be removed, and as far as possible, even the appearance of military control of the medical service assiduously avoided. Let us hope that pending legislation may be brought in line with the worthy ambitions of those now in charge of the Veterans Administration.

ARTERIOSCLEROSIS IN DIABETES

In the July number of *Archives of Internal Medicine*, Herzstein and Weinroth¹ reopen the well worn but unsolved question of peripheral vascular disease in diabetes. They review the voluminous literature and report 249 cases with 51 per cent showing this condition. While the incidence of arteriosclerosis increased with age and was greater in hypertensive cases the difference was not marked. The severity of the diabetes seemed not to play an important roll and youthful diabetics and hypotensive diabetic cases showed a relatively high incidence. The duration of diabetes and the effectiveness of control were not important factors. Of interest to the average doctor is the fact that after sifting all the theories as to the causative factors it is impossible to arrive at a satisfactory conclusion. Our want of knowledge is confirmed by many conflicting opinions. While the discovery of insulin proved to be a great boon, this discussion suggests that it

may not be an unmixed blessing. In this connection, the authors say:

"A higher incidence of premature arteriosclerosis under the newer regimens of liberal diets and insulin might indicate the need for a return to the previously accepted, more rigid standards of control."

Finally Joslin² indicates the need of further study when he points out the fact that deaths from arteriosclerosis have increased three-fold while deaths from diabetic coma have dropped to one-sixteenth of their former incidence.

1. Weinroth, Leonard A.: Arteriosclerotic Peripheral Vascular Disease in Diabetis. Archives of Internal Medicine. Vol. 76, July, pp. 34. 1945.

2. Joslin, E. P.: Treatment of Diabetic Mellitus. Lea & Febiger, Philadelphia. 1940.

THE ART OF MEDICINE PERSONIFIED

Apropos "The Morning Visit" by Oliver Wendell Holmes recently quoted in the editorial columns of the Journal, many American doctors who have given freely of their skill, their time, and their strength, often without remuneration, except the joy of giving, will appreciate this picture of England's Dr. Pritchard, who in the universal spirit of good medical service exercises "the sweet magic of a cheerful face" upon our fellow countryman, J. Frank Dobie¹ of the University of Texas. Though this story has no scientific value, it has great professional virtue.

"Doctor Pritchard looks fiftyish. I met him in the dark days of last November. I had rushed out of a lighted room about eight o'clock one night. Without pausing to accustom my eyes to the blackout, I rammed myself into a cornice that knocked the breath out of me. About three days later, I decided that I had either broken a rib or mashed one of my lungs. Slight of body, bright of eye and face, and gay, but quiet of voice, Doctor Pritchard brought into my room more sunshine than my English winter could afford. He said a rib was only bruised and taped me up. I felt new-made and wore the tape until I came near having to call him to do some skin grafting. Then three or four weeks later I took to moping with what was probably influenza — result of that science-defying amalgamation of dampness, chilliness and stone walls of antiquity. Doctor Pritchard came again and brought sunshine. He paid several calls, though he and all other doctors were rushed to exhaustion in those days.

"Along after New Year's I asked my Cambridge mentor if the doctor would not send a bill. 'He'll send it eventually,' the mentor said. I had learned that bills are often as slow in arriving over here as they are from that old Southern gentleman-styled hotel, the

Driskill in Austin. May its shadow and that of its courtly host never grow less! . . . After waiting for three months, I decided to call on Doctor Pritchard, I just wanted to see him anyhow. In front of a fire in a room with two bright pictures and a graceful ship model on it, he began telling me about two Texans, oilmen, he knew in Persia. One of them was very quiet, never said anything, and had the reputation of being a 'dangerous man'; the other talked a lot and talked loud and one day missed twelve six-shooter shots at a beer bottle.

"It took me several minutes to get to my bill. 'I never keep books,' Doctor Pritchard laughed. Then he began telling me about the prisoner of war who made the beautiful sailing sloop. . . I got back to the bill again.

"'Oh,' he said, 'I wouldn't think of charging an American. You all are over here, you know. There is too much charging going on. We hear about it, and it's a bloody shame.' (As a matter of fact, there is less overcharging of American soldiers in England than there is in American cities frequented by them.) 'I never have charged an American and I won't.'

"I'll have to get even with you somehow," I said.

"'No, it is not a matter of getting even with me. The account has been balanced.'

"I raised my hand at the throb of a great formation of Fortresses coming home from the Continent.

"His keen face brightened. 'Oh, what a sight a great flight of them makes going out in the morning,' he said. 'I always salute them.'

"'Yes, I do too,' I said. 'The roar can never be routine. It is the same at night when the R.A.F. goes out.'

"'When I hear them at night, I go out in the garden and wave to them and wish them good luck. They can't see me. They don't know I am there, but my heart is with them just the same.'

"This made me tell him how for years now I have never seen a bright moon, or the moon at all, without thinking of the R.A.F. and giving them a salute in my soul. Often nowadays they don't want a moon and with their pathfinders they find the target in clouded darkness. But the R.A.F. moon will, as long as I live, be as real to me as the "Comanche moon" was to the frontiersmen of the Southwest.

"I went to a bookstore and, with instructions for proper delivery, bought a copy of a certain book. On the flyleaf of it I wrote: 'Brightness falls from the air — where Doctor S. H. Pritchard walks. This is a salute to

his gallantry and generosity from an American whose life he has brightened."

"But that American does not imagine that twelve shillings and sixpence worth of book has evened up the doctor's bill."

England's panel practice admits of no such practices and inspires no such stories as reported above. What's the use of trying to keep a fellow well and alive without such human relationships. Such is the challenge that comes from the Divine, not the bureaucrat.

1. Dobie, J. Frank: *A Texan in England*. Little, Brown and Company. pp. 52-55. Boston, 1945.

PEOPLE WHO ARE WINGED SHOULD NOT FLY

In the past people suffering from advanced tuberculosis were occasionally referred to as being winged. Since artificial pneumothorax has assumed such an important role in the treatment of all stages of pulmonary tuberculosis many people have only one lung insofar as function is concerned. Such people are truly winged in that they cannot fly without great danger. In 1942, Lovelace¹ discussed the dangers of aerial transportation to persons with pneumothorax and pointed out the fact that a patient at sea level with 1000 cc. of air in the pleural space will have the equivalent of 1500 cc. at an altitude of 10,000 feet and the pneumothorax space will be correspondingly enlarged in case the walls of the space are reasonably flexible. If the walls are inflexible because of thickened pleura and adhesions, the intra pleural pressure will be increased. The expansion or the pressure or both are increased at a more rapid ratio as additional altitude is attained.

In the June, 1945 issue of the American Review of Tuberculosis, Bridge and Bridge² discuss the effects of altitude on abnormal accumulations of air in the chest. They list the following chest lesions as potentially hazardous for flying because they involve abnormal accumulations of air.

"1. Pneumothorax:

- A. Uncomplicated types: Unilateral, bilateral, intrapleural or extrapleural.
- B. Complicated types: visceroparietal adhesions, mediastinal hernia.

"2. Pulmonary cavity:

- A. Closed communication with a bronchus occasioned by fluid within the cavity, or
- B. Intermittent communication with a bronchus occasioned by 'check-valve' structures.

"3. Emphysema:

- A. Pulmonary.
- B. Mediastinal.
- C. Subcutaneous."

The inherent dangers are due to air expansion and the pressure differential as the

patient passes from sea level to altitude. The relative dangers depend upon the pathologic conditions and the altitude attained. The authors believe the following conditions contraindicate air travel for patients with abnormal accumulations of air in the chest.

"1. Cyanosis or dyspnea, 2. Recent hemoptysis, 3. Visceroparietal adhesion, 4. Mediastinal hernia, 5. Mediastinal displacement, 6. Pulmonary cavity containing fluid or with signs of intermittent bronchial communication or with closed bronchial communication, 7. Mediastinal emphysema, 8. Pulmonary emphysema with dyspnea."

Because of the rapidly increasing popularity of therapeutic pneumothorax and air transportation this discussion deserves serious consideration by both doctor and patient. J. Frank Dobie, after flying over the ocean without seeing it, made a distinction between transportation and travel. Those who are winged should just travel.

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2. Bridge, Ezra and Bridge, Ezra: American Review of Tuberculosis. Vol LI, 6, pp. 532-536, June 1945.

A WHALE OF A JOB

Adequate medical care of a hundred million otherwise free people, through the expenditure of three and a half billion dollars otherwise belonging to a hundred and thirty million good citizens is a whale of a job.

If our modern Jonah, Mr. Wagner, swallows this whale he will need the personal services of a good gastroenterologist.

Vesperal

From light to dark, from dark to light.
I know the night is near at hand.
The mists lie low on hill and bay,
The autumn sheaves are dewless, dry;
But I have had the day.
Yes, I have had, dear Lord, the day;
When at Thy call I have the night,
Brief be the twilight as I pass
From light to dark, from dark to light.
—S. Weir Mitchell. *A Physician's Anthology of English and American Poetry*, p. 333.

Wyeth and Yellow Fever The War Machine Hoch Der Kaiser!

I am the Right-Divine,
Heaven and Earth are mine;
If you question my right
You must stand up and fight.
Behold! My Battle-line!

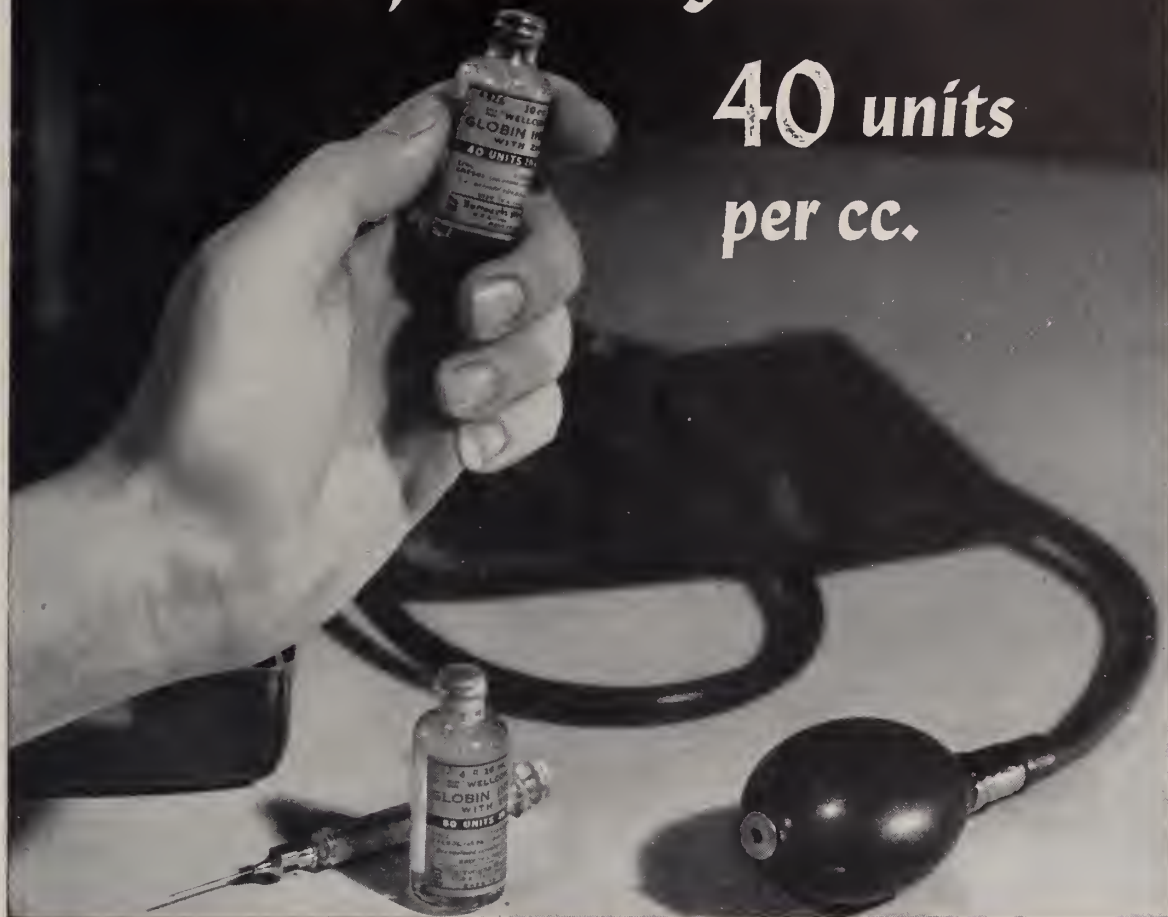
Come to the War-Lord's feast,
Men of the West and East;
Hear me pray to my God
As I fatten the sod
With bones of man and beast.

Mine is the War-Machine.
The earth that once was green,
I make red with the blood
That I shed in a flood
In the name of the Nazarene!

John Allan Wyeth. *With Sabre and Scalpel*. p. 527. 1924.

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40 units per cc.



THE NEW STRENGTH of 'Wellcome' Globin Insulin with Zinc, 40 units per cc., gives the physician greater flexibility in prescribing globin insulin to meet patients' needs. The lower strength is particularly suitable for milder cases where fewer units are needed for diabetic control. While the U-80 continues in wide use, especially for moderately severe and severe cases, the new strength enables the practitioner and patient to meet insulin requirements more closely.

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ASSOCIATION ACTIVITIES

SURGEON GENERAL ANNOUNCES NEW OFFICER RELEASE POLICY

A revised point system program which will return 13,000 physicians, 25,000 nurses, 3,500 dentists and an undetermined number of other Medical Department officers to civilian life by 1 January 1946 was announced 14 September 1945 by Major General Normal T. Kirk, the Surgeon General.

Under the plan those Medical and Dental Corps officers who have 80 points, are 48 years of age or have been in the Army since Pearl Harbor will be released as surplus officers unless they are specialists in eye, ear, nose and throat work, plastic surgery, orthopedic surgery, neuropsychiatry or are laboratory technicians. These specialists will be released if they were called to active duty prior to 1 January 1941.

This is a drastic lowering of points below the previous plan which was based on an adjusted service score of 100 for non-scarce Medical Corps officers and 120 for those in scarce categories.

A similar drastic reduction was made in the point score for nurses, who are now eligible for discharge if their rating is 35 or more, or if they are 35 years old. In addition all married nurses and those with children under 14 years are eligible for immediate separation. Physician Therapists and Dietitians are eligible under the same conditions if their point score is 40 or more, or if they are 40 years old.

Veterinary Corps officers will be eligible for discharge if they have a point score of 80 or more, if they are 42 years old, or if they joined the Army prior to 1 January 1941.

INTERESTING, WELL ATTENDED MEETING HELD AT McALESTER

(Editor's Note: Due to lack of space, this report did not appear in the previous issue of the Journal.)

On June 28, 35 members of District No. 9 met for dinner at Krebs, after which they gathered for a meeting at the Pittsburg County Health Unit in McAlester. Dr. Earl Woodson, Councilor, opened the meeting with a statement that it was the general feeling of the County Societies that the State Association Program was definitely a step forward. He briefly outlined the recent legislation and urged the members to write for copies of the health bills passed. Dr. Woodson then turned the meeting over to Dr. Tisdal, President of the Association.

Dr. Tisdal explained the wish of the Association to have a closer cooperation with the county units. He also expressed the importance of letting the people know that the medical profession is vitally interested in their welfare.

Dr. Clinton Gallaher, Shawnee, as first speaker on the program opened his speech with a quotation of Dr. McLain Rogers', "Everything you do has political significance. The trouble with the doctors is that they let the other fellow run it." He further stated that the physician is the best qualified to tell the people about the progress of medical science. Dr. Gallaher stressed the importance of getting the young men interested in the County Societies and the Association.

Dr. Tom Lowry, Oklahoma City, Dean of the Medical School, was next called on for a few words. He expressed appreciation to the doctors for their part in the passing of the medical school appropriation bill.

Dr. Grady Mathews, Commissioner of Health, was the next speaker and opened his talk by a brief history and description of the various county health units over the

state. He then gave statistics on the causes of death in Oklahoma from preventable diseases. Public health, explained Dr. Mathews, is not the care of the indigent but deals in sanitation and in communicable diseases.

The next speaker on the program was Dr. Ralph McGill of Tulsa, representing the Cancer Committee of the State Association. Dr. McGill told of the recent drive for funds and asked for suggestions as to how to spend the money raised in the drive. He outlined the tentative plan as; public education, tumor clinics, research and care to the incurable.

At this point in the program Dr. Woodson introduced the members of the Navy who were present: Lt. Julia Niekoski, Lt. Comdr. R. R. Kies and Lt. C. L. Tefer-tiller and Major Stafford of the U. S. Army.

Mr. Paul Fesler, Executive Secretary of the Association, was next called upon. He said, in part: "The State Board of Health is for the good of the people of the State." Mr. Fesler then discussed the hospital situation of the state, saying that there should be four beds per thousand population and at the present time the state only had one bed per thousand. He stated that it was not necessary to build large hospitals, that a group of smaller ones would suffice but that people like to be near home when they are sick and need hospital attention. In discussing the University Hospital, Mr. Fesler explained that it was up to the doctors of the state to see that only teaching patients were sent into the hospital.

The Wagner Bill was the next subject for discussion and Dr. L. C. Kuyrkendall of McAlester, President-Elect of the Association was the speaker. Dr. Kuyrkendall explained the pitfalls of the Senate Bill 1050 and urged the doctors to read and understand the bill and then to tell their patients about it. He stressed the danger of lack of education to the public and said that it was evident that the people didn't know what the Bill contained and as a result had done nothing to prevent its passage.

Dr. James Stevenson, Tulsa, the next speaker discussed the Prepaid Surgical Plan and the National Physicians Committee. In discussing the National Physicians Committee, Dr. Stevenson pointed out the fight that the Committee was making against the Wagner Bill and urged the members to contribute any sum they wished to help in this fight. With regard to the Prepaid Surgical Plan, he explained that it was necessary that the County Society ask for the plan before it could operate in the county.

Dr. Carl Puckett, Oklahoma City, of the State Tuberculosis Association, in discussing the "Eradication of Tuberculosis" outlined the activities of the Association along this line. Dr. Puckett stated that the Association had various booklets and pamphlets available and anyone desiring a supply should write to the State Office in Oklahoma City and they would be glad to send them.

The closing speech of the meeting was delivered by Dr. E. N. Smith of Oklahoma City who delivered a very interesting scientific discussion of "Enclampsia."

DR. CALDWELL MAKES OKLAHOMA HOSPITAL SURVEY

Dr. Bert W. Caldwell, former Executive Secretary of the American Hospital Association has been engaged to make a survey for the State Board of Health of the hospital facilities of Oklahoma.

Dr. Caldwell practiced medicine in Oklahoma from 1903 to 1908 at Hugo.

ATTENTION: EX-SERVICE MEN

The State Association office has learned that Doctors from the Armed Services have experienced unnecessary delays because they were not apprised of the necessity of securing a registration certificate from the Oklahoma State Board of Medical Examiners before they can legally practice and before they can secure a narcotic certificate. The fact that the fees were waived during the period of Military service does not alter the situation.

We quote from a letter just received from the Secretary of the Board: "It is true, however, under the law, that one must be in possession of his renewal certificate before practicing medicine and surgery in the State of Oklahoma. Therefore, the first thing that these men should do is to apply to the office of the Oklahoma State Board of Medical Examiners for a renewal permit. If they have filled out one of the original questionnaires sent out from this office, all they need to do is to send their fee of \$3.00 in. If they have never filled out one of the original questionnaires, they should request a questionnaire, and as soon as they can complete it, send it to this office with the fee of \$3.00." Address: Board of Medical Examiners, J. D. Osborn, Secretary, Frederick, Oklahoma.

SPEAKERS CALLED UPON FOR SHATTUCK MEETING

On September 14 the Woodward County Medical Society held a meeting at the Newman Clinic in Shattuck. Before the business a dinner was served at the First Methodist Church.

The Speakers from the Speakers Bureau of the Oklahoma State Medical Association were Dr. C. R. Rountree of Oklahoma City who spoke on the Wagner-Murray-Dingell Bill and Dr. J. E. Levick of Elk City who discussed the Military Aspects of Neuropsychiatry. Mr. Paul H. Fesler, Executive Secretary of the Oklahoma State Medical Association briefly discussed the Hill Burton Bill and the hospital survey being conducted in Oklahoma at the present time.

Dr. C. W. Tedrowe, Woodward, Secretary of the Society spoke on the value of the National Physicians Committee and the things that could be accomplished by the advertising the Committee makes available. A motion was made and seconded that each member of the Society contribute \$25.00 to the National Physicians Committee.

DICK GRAHAM RETURNS TO EXECUTIVE OFFICE

Captain R. H. Graham formerly of the Surgeon Generals Office in Washington is once more our familiar "Dick" Graham, Executive Secretary of the Oklahoma State Medical Association.

On October 1, Dick once again assumed his duties as Executive Secretary and will carry on in his usual inimitable way.

INTERNATIONAL COLLEGE OF SURGEONS MEETS

The International College of Surgeons will hold its Tenth Annual Convention and Convocation on December 7 and 8, 1945, at the Mayflower Hotel, Washington, D. C. At this time approximately 200 men will receive their Fellowship. A scientific program is planned for both days. Convocation exercises will be held Friday evening, December 7, in the Mayflower Auditorium.

HENRY H. TURNER INSTRUCTOR FOR POSTGRADUATE COURSE IN ENDOCRINOLOGY

From November 5 to November 10 the American College of Physicians will conduct a Postgraduate Course in Endocrinology in Chicago. Dr. Henry H. Turner, Oklahoma City, will lecture on the Clinical Use of Testosterone and Persistence of Estrogenic Effects.

URGENT REQUEST FOR PERSONNEL TO STRENGTHEN CHINESE PERSONNEL

The Chinese Government has requested the United Nations Relief and Rehabilitation Administration to provide, as soon as possible, some 200 field personnel of the following categories to strengthen the available Chinese personnel. Such personnel will be required to head the respective services in hospitals of 100 or 250 beds, which will be established in areas recently liberated from the Japanese. General Surgeons; Orthopedic Surgeons; Genito-Urinary Surgeons; Gynecologists and Obstetricians; General Physicians; Dermatologists and Syphilologists; Ophthalmologists; Otolaryngologists; Radiologists; Dentists; Pediatricians; Laboratory Technicians; X-Ray Technicians; Sanitary Engineers; Public Health Engineers; Public Health Nurses; Clinical Nurses.

General practitioners with some specialist experience will be acceptable. Candidates should be under 55 years of age and in good physician condition.

Those interested please write to Szeming Sze, M.D., Chief, Far East Section, Health Division, United Nations Relief and Rehabilitation Administration, 1344 Connecticut Avenue, N. W., Washington 25, D. C.

WILLIAM E. EASTLAND, M.D.

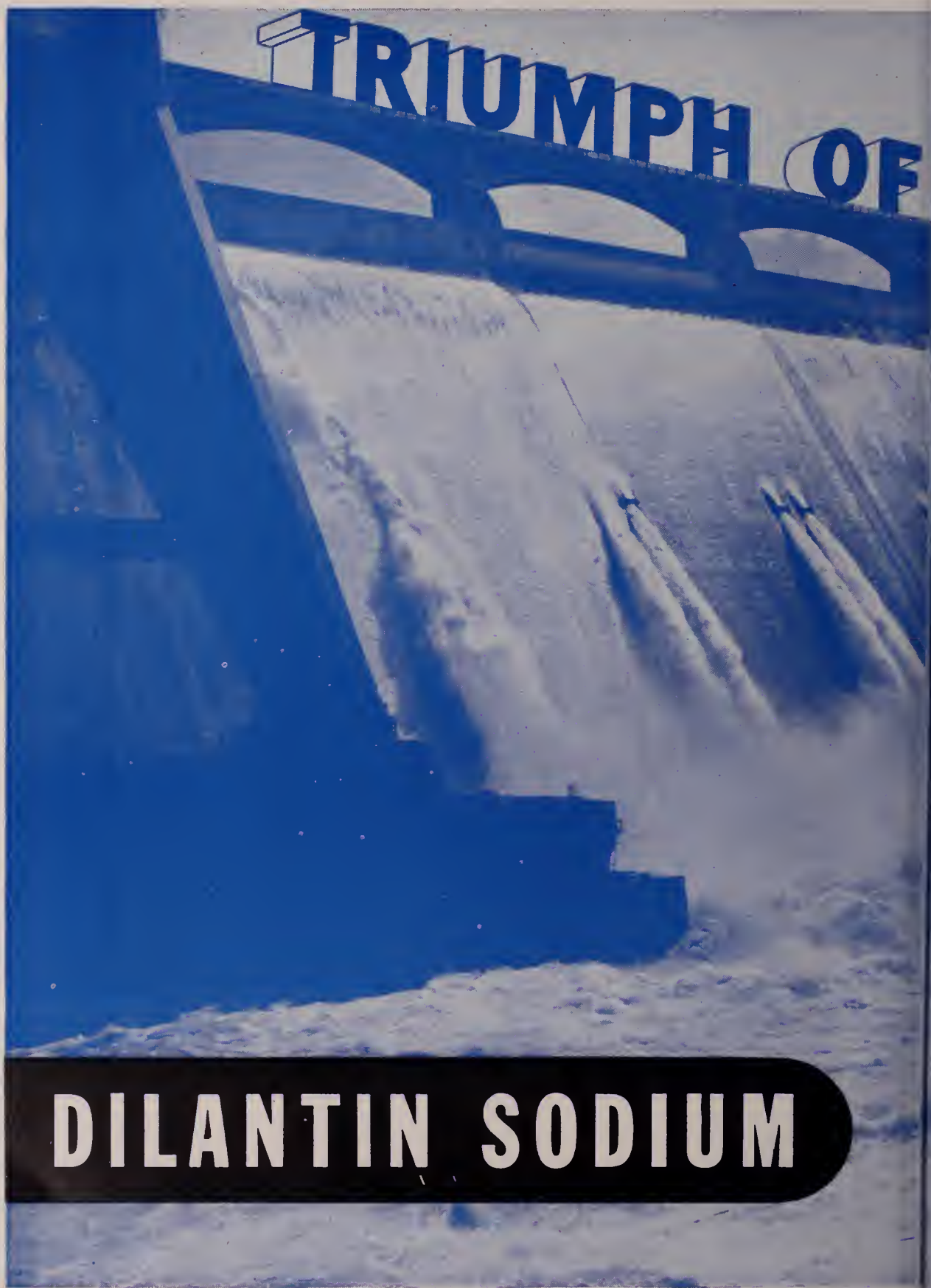
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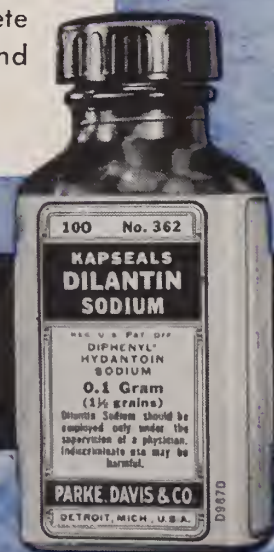


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RADIO BROADCAST—WNAD

Wednesday—October 3

5:15 P.M.

GOVERNOR KERR—This is the introduction to a series of broadcasts from this radio station relative to the health of the people of Oklahoma. The Oklahoma Legislature has inaugurated a great health program which, if carried out as planned, will make it possible for people even in the most remote districts of the state to have adequate medical and hospital facilities. The success of this program will depend on the School of Medicine of the University of Oklahoma, the Oklahoma State Medical Association, the State Board of Health and the cooperation of the citizens in each community.

In order to present the program to you I have requested Dr. Tom Lowry, Dean of the University of Oklahoma School of Medicine, Dr. V. C. Tisdal, President of the Oklahoma State Medical Association and Dr. Grady Mathews, State Commissioner of Health to explain its operation. Each Wednesday over this station, health subjects will be discussed by leaders in the field of health education and the medical profession. All of the speakers are well qualified and it is hoped that you will listen to these broadcasts as everything said will be for the purpose of informing you in regard to improving and caring for your health. There is nothing more important. Health is an individual and community problem of great social and economic significance. I know that you are interested. We are grateful to Radio Station WNAD for making these broadcasts possible.

Dr. Lowry, the School of Medicine of the University of Oklahoma should be the fountainhead of medical and health education. As Dean of this School, how can it participate in this program.

DR. LOWRY—Governor Kerr, the School of Medicine is glad to assume its responsibility in medical and health education. We realize that the people of the United States lose ten billion dollars every year as a result of illness, that illness generates poverty which in turn generates more illness: that every case of premature death is a capital loss to the nation. And may I add that it seems almost a mockery that we spend 378 million dollars a year on industrial research for inventing gadgets and chemicals and only 12 million dollars of medical research to enable people to live longer so they can enjoy these gadgets.

GOVERNOR KERR—Dr. Lowry, the school of medicine made a great contribution toward winning this war. Would you care to comment on this subject?

DR. LOWRY—The doctors and nurses in this World War have made a magnificent record in medicine. Our military forces have had the best medical care in the world. For example, the mortality from meningitis was reduced from 38 per cent in World War I to 4 per cent in World War II. Pneumonia from 28 per cent in World War I to 1 per cent in World War II. Mortality from wounds was reduced from 8.1 per cent to 3.3 per cent—and only a few more than 3,000 soldiers died from disease in World War II, where 243,000 died from disease in the Civil War. Governor, we realize that this brilliant record was made because the Armed Forces had an adequate number of doctors, an adequate number of hospital beds, and last, they had regimentation of patients. This brilliant health record is a challenge to us as civilians. But, in order for us at home to approach this record, we must have an adequate number of doctors, an adequate number of hospital beds and we must substitute health education for regimentation.

GOVERNOR KERR—Dr. Lowry, does the School of Medicine have any definite plans for broadening its program of medical and health education?

DR. LOWRY—Yes, Governor Kerr, the School of Medicine will raise the level and broaden the base of medical and health education in this State. In order to carry on this program we will need more trained personnel. Oklahoma's 20th Legislature provided for these needs by appropriating \$1,480,000 for a building

program for the School of Medicine and the University Hospitals.

It is the plan of the University of Oklahoma in cooperation with the School of Medicine to develop a school of Public Health, to train sanitary engineers, public health nurses and public health doctors. We hope to develop a department of physical medicine to train physio-therapists, also a graduate school of nursing. These, in addition to a school of laboratory technicians, x-ray technicians and dietitians, which we now have, will be a very broad program.

GOVERNOR KERR—Doctor, does the School of Medicine have a post war program for veterans?

DR. LOWRY—Yes, Governor. The School of Medicine plans to double the number of resident services in the hospitals and the curriculum has been prepared for a refresher course of one month in medicine and one month in surgery which will be available to our doctors returning from military service.

GOVERNOR KERR—Dr. Tisdal, as President of the Oklahoma State Medical Association and as a member of the Oklahoma State Board of Health, you have been very active in the initiation of this program. Will you please explain this program and enumerate the benefits which it will bring to the people of Oklahoma.

DR. TISDAL—The medical profession is most conscious of the benefits which a progressive health program can bring to the people of Oklahoma. The Oklahoma State Medical Association approved and supported all of the health bills passed by the 20th session of the Oklahoma Legislature. They also adopted a constructive program for medical care for the people of Oklahoma.

GOVERNOR KERR—Just what are your plans for health education, Dr. Tisdal?

DR. TISDAL—First, we expect to use the press, the radio, the speakers bureau—yes, and visual education to inform the people about health. By these methods and through our committees of the Oklahoma State Medical Association, we hope to improve living conditions, improve housing, nutrition and sanitation, which are fundamentals to good health. We also hope to inform people how to prevent, detect and manage certain problems of health, both for the individual and the community.

GOVERNOR KERR—Dr. Tisdal, we have been told that the rich and the indigent receive the best medical care while the man in the middle-and-low-income group is often financially unable to provide adequate medical and hospital care for his family; does your program provide any methods to improve this condition?

DR. TISDAL—Yes, Governor. The American Medical Association and the Oklahoma State Medical Association have both endorsed voluntary hospital and voluntary medical and surgical plans. In fact, the Oklahoma State Medical Association 5 years ago started the Blue Cross non-profit hospital program. We now have 115,000 members in Oklahoma. We very recently started a Prepaid, non-profit Surgical Plan which is now in force in nine counties with an approximate membership of 600. By this method a family can be assured of good medical and hospital care by the payment of a small monthly premium with the privilege of selecting his own doctor. We hope that this service will soon be available to all families in this income group.

GOVERNOR KERR—Isn't it true, Dr. Tisdal, that Oklahoma has an inadequate number and unequal distribution of doctors?

DR. TISDAL—Yes, Governor. Doctors tend to locate in cities where they have adequate hospital facilities. The Oklahoma State Medical Association has a bureau of information which gives essential data on every community, and we are trying to help relocate good doctors in every community. *The establishment of good hospitals in rural areas will be the greatest inducement for doctors to locate in those sections of the state.*

GOVERNOR KERR—Dr. Mathews, since most of the health legislation passed by the 20th session of the Legislature placed the responsibility for making such

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*Larsen, N. P.: Observations with Penicillin, Hawaii M. J. 3:372 (July) 1944.

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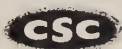
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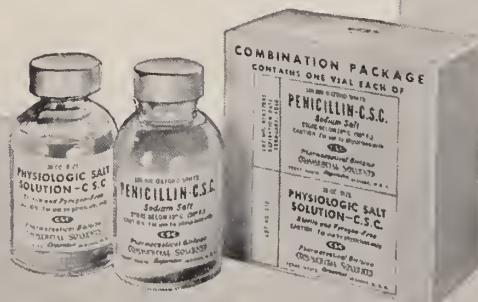
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legislation effective upon you as Health Commissioner, will you discuss for us, one or two of the laws which you consider most beneficial in improving the health of the people of the state.

DR. MATHEWS—Governor, as I see it, the most important pieces of health legislation were the establishing of a Board of Health consisting of nine members, appointed by the Governor and distributed geographically according to the congressional districts, and the law which authorizes a survey to be made of existing hospital facilities. This latter piece of legislation is so far reaching because it pertains to the improvement of the health facilities of the state, that an entire broadcast will be devoted to this subject at a later date. I am convinced that the creation of the Board of Health will stabilize and strengthen the State Department of Health and also that it will carry information regarding public health to every section of the state as it has never been carried before. The men and women who serve on this Board will be anxious to interpret the services of the Health Department to their own communities and this will be far more effective than any other publicity. As time passes and personnel is available, we expect to establish local health departments in sufficient number and in strategic locations so that the services offered by the Health Department will be available to every person in the state. This was made possible by another piece of legislation which appropriates \$3,000.00 State Funds to any county which will meet certain appropriation schedules.

GOVERNOR KERR—Are the Counties and Municipalities interested in establishing these local health departments?

DR. MATHEWS—Yes, Sir. They are vitally interested. At the present time, we have requests for establishing health departments in some 12 or 15 counties. Some of these will group together two or three counties to form a health district and others will be one county units.

GOVERNOR KERR—What is the possibility of establishing these local health Departments? What is causing a delay?

DR. MATHEWS—The shortage of properly trained personnel. Just as soon as doctors, nurses, and sanitarians are available, these departments will be established.

GOVERNOR KERR—Dr. Mathews, what piece of legislation is next in importance to the building of better health in the state?

DR. MATHEWS—As we look to the future, we are convinced that the prenatal law, the law requiring an examination for syphilis of all pregnant women, is sound and will reduce to a minimum, the number of babies born affected with congenital syphilis. Closely related to this law and of equal importance is the premarital law requiring the contracting parties to have an examination for venereal diseases.

It is difficult to choose the most constructive piece of legislation among the 15 or 16 health bills, which were enacted by the 20th Legislature. Even though a special broadcast will be devoted to the subject, I should like to mention the legislation which permits the State Department of Health to make a survey of existing hospital facilities. The data collected and assembled will be used by the Commissioner of Health and his advisory Board in recommending the establishment of additional

hospital facilities so located that they will be accessible to all citizens of the State. This, in coordination with the voluntary hospital and medical plans being sponsored by the Oklahoma State Medical Association will place hospital and medical care within the reach of most groups regardless of income. Federal legislation is also pending which will make available, to various units of government, Federal funds to be used in the establishment of such hospitals and health centers. This is Senate Bill 191, the Hill Burton Bill.

GOVERNOR KERR—Dr. Mathews, while I realize the subject is comprehensive, could you tell us something about the medical care of those people who are dependent upon public funds for their well-being?

DR. MATHEWS—Governor Kerr, contrary to the general public's conception of this type of care, it is NOT a responsibility of the public health Department. As you know, under our State laws the complete care of the indigent person is a responsibility of the County Commissioners in the county in which he lives. However, the following agencies in addition to the County Commissioners aid and assist in caring for indigent people: The Crippled Children's Commission; the State Board of Public Welfare and the Oklahoma Public Welfare Commission.

GOVERNOR KERR—Thank you, Dr. Mathews. It occurs to me that the Legislature increased your responsibility two or three fold, and I am glad to see that you are accepting this responsibility and are taking the necessary steps to vitalize these important pieces of legislation.

May I also thank you gentlemen for your well correlated discussion of Oklahoma's Health Program. I repeat that we are grateful to Station WNAD for this broadcast period. Remember, a similar health program will be broadcast from this station every Wednesday at this time. They will be interesting and they may prolong your life. A healthy nation is a progressive nation. Thank you.

ANNOUNCER—Reprints of this broadcast may be obtained by addressing a communication to either this station or to the Oklahoma State Medical Association, 210 Plaza Court, Oklahoma City 3, Oklahoma.

INSTITUTE OF NEUROPSYCHIATRY MOVES OFFICES

This is to announce that for convenience and because of the difficulty of working out a satisfactory schedule to fit into being at both places at the same time, The Coyne Campbell Sanitarium has moved its offices out of the Medical Arts Building back to the Sanitarium at 131 N. E. 4th St., Oklahoma City 4, Oklahoma.

A Doctor's Prayer

"O Lord, give me knowledge, and the art of expression, for the conveyance of the same to others; give me a laudable urge for the acquisition of new truths and give me a skill and dexterity in their application; give me poise, wisdom and sympathy as I approach the sick, and free my soul from unjust discrimination; Give me strength and the will to carry on against all odds and most of all, give me humility."

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Legal Opinions

STATE OF OKLAHOMA
Office of the Attorney General
Oklahoma City
May 11, 1942

Dr. James D. Osborn, Secretary,
Oklahoma Board of Medical Examiners,
Frederick, Oklahoma.

Dear Sir:

The Attorney General acknowledges receipt of your letters dated April 3 and May 4, 1942, wherein you, in effect, ask:

- (1) Is it a violation of the Medical Practice Act of this State for a registered nurse to administer local or general anesthetics under the direction and in the presence of a duly licensed physician and surgeon of this State?
- (2) Is it a violation of the Medical Practice Act of this State for a physician and surgeon who is not licensed in this State, to perform the usual duties performed by internes in recognized hospitals of this State?

In reply, you are advised that 59 O. S. 1941 (491) makes it a misdemeanor for a person to practice medicine and/or surgery in the State without having the legal possession of an unrevoked license to so practice. Section 492 *idem*, which defines the practice of medicine and surgery in this State, is in part as follows:

"Every person shall be regarded as practicing medicine within the meaning and provisions of this Act, who shall append to his name the letters 'M.D.' 'Doctor,' 'Professor,' 'Specialist,' 'Physician,' or any other title, letters or designation which represent that such person is a physician, or who shall for a fee or compensation treat disease, injury or deformity of per-

sons by any drugs, surgery, manual or mechanical treatment whatsoever."

Section 493, *idem*, impliedly authorizes a graduate of a legally chartered medical school or university, "the requirement of which for graduation shall have been, at the time of such graduation, in no particular less than those prescribed by the Association of American Medical Colleges for that particular year," to perform duties such as are usually performed by an interne, in a general hospital in this State which is approved and recognized by your Board.

In 48 Corpus Juris, page 1079, Section 31, the following general rule is set forth:

"Where a person without a license or certificate performs acts constituting the practice of dentistry, medicine, or surgery, he is not relieved from liability therefor by the fact that he performs the acts as an assistant to, or under the direction and supervision of, a duly authorized practitioner, unless he is within an express statutory exemption. However, the services of an ordinary nurse performed under the direction of a duly qualified surgeon are not within the statute."

Corpus Juris cites, in support of the last sentence of the above quoted language, the case of *In re Carpenter*, 162 N. W. 963, but an examination of said case reveals that the statute therein construed is so dissimilar to Section 492, *supra*, that same, while persuasive, is not controlling here. The first portion of the above quoted general rule clearly states that if an act constitutes the practice of medicine, as defined by the applicable statute (Section 492), the mere fact that the act is performed under the direction of a licensed physician and surgeon is not material. It will be here noted that if the rule were otherwise a layman could, for compensation, lawfully perform a major surgical operation under the direction of a licensed physician and surgeon. The question, therefore, arises as to whether or not a registered nurse, such as is mentioned in your first question, who administers a local or general anesthetic for a fee or compensation, is actually treating

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"disease, injury or deformity of persons by any drug, surgery, manual or mechanical treatment whatsoever."

We have been unable to find any case construing a statute, such as is involved here, which holds whether or not the administration of a local or general anesthetic constitutes the *treatment* of disease, injury or deformity, as above defined. However, we have found a number of cases construing statutes neither identical nor similar to Section 492, *supra*, in relation to the question as to whether or not the administration of anesthetics constitutes the practice of medicine or surgery thereunder, and all of said cases hold that such administration does not constitute the practice of medicine and surgery within the meaning of said statutes. In fact, some of said cases state that the usual practice in hospitals throughout the United States, including Mayo's, is to permit registered nurses and technicians to administer anesthetics preliminary to and during surgical operations. In this connection attention is called to the case of *Chalmers-Francis, et al. v. Nelson, et al.* (Cal—1936), 57 Pac. (ed) 1312, the syllabus of which is as follows:

"Licensed and registered nurse, employed by hospital, who administered general anesthetics in connection with operations under direction of operating surgeon and his assistants, HELD not engaged in illegal 'practice of medicine' in violation of Medical Practice Act, since nurse was not 'diagnosing' or 'prescribing' while assisting in surgery and his activities were under control of surgeons (St. 1913, p. 722, as amended)."

Attention is also called to the 16th paragraph of the syllabus of *Pacific Mutual Life Insurance Company v. Cunningham*, 54 Fed. (2d) 927, the cases cited in support thereof, and to the fact that while the laws of this State (59 O. S. 1941(551 to (564, inclusive,) relating to "nurses" provide that it is unlawful for any person to practice nursing "as a trained graduate or registered nurse or to engage in the care of the sick as licensed attendant" without having a certificate from the State Board of Nurse Examiners, the practice of nursing, itself, is not defined.

It is, therefore, the opinion of the Attorney General that it is not a violation of the Medical Practice Act of this State for a registered nurse to administer local or general anesthetics under the direction and in the presence of a duly licensed physician and surgeon of this State.

In reply to your second question, you are advised that, assuming the unlicensed physician and surgeon mentioned by you performs acts constituting the practice of medicine and surgery in this State, as defined by said Section 492, it will be a violation of Sections 491 and 492, *supra*, for him to perform said acts unless he is serving a one-year's internship in a general hospital which is approved and recognized by your Board, and be a graduate of a legally chartered medical college or university, the requirements of which for graduation shall have been, at the time of his graduation.

"in no particular less than those prescribed by the Association of American Medical Colleges for the particular year."

We are returning the correspondence which was attached to your letters, herewith.

Yours respectfully,
FOR THE ATTORNEY GENERAL
Fred Hansen
Assistant Attorney General.

FH:VR
Enc.



THE VICTORY MEETING of the Southern Medical Association will be held under the sponsorship of the Campbell-Kenton County Medical Society of Kentucky in Cincinnati, Ohio, November 12-15. It is a Kentucky meeting. The Southern Medical Association meetings always have been and always will be the essential meetings IN and FOR the South. The Southern as an essential medical organization has carried on without a break during the war—it has not missed a meeting. Now it will celebrate the victory with a great VICTORY MEETING. In its twenty-one sections, two general sessions, six conjoint meetings, and the scientific and technical exhibits, in a streamlined program, one will get the last word in modern, practical, scientific medicine and surgery.

REGARDLESS of what any physician may be interested in, regardless of how general or how limited his interest, there will be at Cincinnati a program to challenge that interest and make it worth-while for him to attend.

ALL MEMBERS of State and County medical societies in the South are cordially invited to attend. And all members of state and county medical societies in the South should be and can be members of the Southern Medical Association. The annual dues of \$4.00 include the Southern Medical Journal, a journal valuable to physicians of the South, one that each should have on his reading table.

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FIGHTIN' TALK

**Oklahoma County**

OFFICERS: President, Mrs. Gerald Rogers; President-elect, Mrs. William E. Eastland; Vice-President, Mrs. John S. Pine; Recording-secretary, Mrs. William L. Bonham; Corresponding secretary, Mrs. Meredith M. Appleton; Treasurer, Mrs. John F. Kuhn, Jr.; Assistant treasurer, Mrs. P. K. Graening; Parliamentarian, Mrs. Walker Morledge; Press and Publicity, Mrs. Kenneth J. Wilson.

COMMITTEE CHAIRMEN: Program, Mrs. Grider Penick; Entertainment, Mrs. D. H. O'Donoghue; Social Service, Mrs. Milton Serwer; Scrap Book, Mrs. A. M. Young III; Membership and Visiting, Mrs. Howard Shorbe; Laying, Mrs. Robert I. Trent; Flowers, Mrs. James R. Reed; Hygiene, Mrs. Charles M. O'Leary; Public Health and Relations, Mrs. F. Maxey Cooper; Historian, Mrs. C. R. Rountree; Emergency Fund, Mrs. Gregory E. Stanbro; War Work, Mrs. Harold J. Biuder.

The Auxiliary to the Oklahoma Medical Society held their first meeting of the fall on September 28th, in the home of Mrs. D. H. O'Donoghue, 1403 Glenwood Avenue. As is the custom, this meeting consisted of a Registration Tea between the hours of 3 and 5. A large number of old and new members attended, and while the membership is not up to the 151 of last year, Mrs. Gerald Rogers, president, expects to exceed this before many months. Special guests were the Medical Officers wives from Tiuker Field, Will Rogers Field and the Navy Hospital at Norman. The next meeting will be October 24th.

Pottawatomie County

Officers and Committee Chairmen: President, Mrs. E. Eugene Rice; Vice-president, Mrs. Charles W. Haygood; Secretary-Treasurer, Mrs. Frank Keen; Program Committee, Mrs. R. M. Anderson; Mrs. W. M. Gallaher.

The Auxiliary to the Pottawatomie County Medical Society met in the home of Mrs. R. M. Anderson, Shawnee, on September 26th. This was the first meeting of the year. A lovely luncheon was served by the hostess to many old members and two new ones, Mrs. Jack W. Baxter and Mrs. J. N. Owen, Jr.

Tulsa County

Officers: President, Mrs. Charles H. Haralson; President-elect, Mrs. D. W. LeMaster; Vice-president, Mrs. W. A. Dean; Recording secretary, Mrs. Ellis Jones; Corresponding secretary, Mrs. Eric White; Treasurer, Mrs. Ralph McGill; Historian, Mrs. J. W. Childs; Parliamentarian, Mrs. C. C. Hoke.

Committee Chairmen: Program-Health-Education, Mrs. S. J. Bradfield, Mrs. H. A. Ruprecht; Year Book, Mrs. D. W. LeMaster; Membership, Mrs. W. A. Dean; Telephone, Mrs. H. W. Ford; Social, Mrs. D. L. Mishler, Philanthropic, Mrs. Hugh Perry; Publicity, Mrs. Eric White; Legislation, Mrs. Frank Nelson; Hygiene, Mrs. Frank L. Flack, Mrs. Walter A. Larrabee; Courtesy, Mrs. Johna Perry; Public Relations, Mrs. W. A. Showman, Mrs. C. S. Summers; Advisory Council, Dr. John Perry, Dr. Ralph McGill, Dr. James Stevenson; Auxiliary Representative, Mrs. Carl Hotz.

The Auxiliary to the Tulsa County Medical Society held their first meeting of the year in the home of their president, Mrs. Charles H. Haralson, No. 1 E. 26th Street, on the morning of October 2nd. This traditional get-together is always anticipated by all members.

Many were welcomed back, who had been with their husbands, who were in the service of their country. Mrs. Gastineau, formerly of Norman, but recently moved to Tulsa, was among those present. The Social Committee was in charge of the Coffee. Late orchestral recordings furnished a pleasing background to the chatter. Mrs. W. A. Dean, membership chairman, reported 117 paid members and several courtesy memberships for those whose husbands are still in the service. The first Tuesday of each month is the regular meeting day.

HOW WE CAN BEST SERVE

Mrs. Jesse D. Hamer, Phoenix, Arizona
President-elect, Auxiliary to the
American Medical Association
(Reprinted from The Bulletin)

The question of how we, as members of the Woman's Auxiliary to the American Medical Association, can render the greatest service to the medical profession and to the public at large, is uppermost in the minds of many of us.

Before it is possible to do effective work in any organization, the members must first be fully informed as to the organization's aims and purposes as well as the policy pursued in carrying out such objectives. This is true in the Woman's Auxiliary to the American Medical Association as it is in any other group.

Holding a membership in the medical auxiliary is a great privilege, which in turn carries with it many responsibilities to both the medical profession and to our respective communities. One of the auxiliary's main objectives is the promotion of health in all its phases. The medical profession is today facing the greatest challenge in its history. As auxiliary members, we must be so well informed on all legislation—federal, state and local—that we can interpret to the public, correctly and fairly, any issue which pertains to health whenever the opportunity presents itself. You may ask how we can do this. It is generally conceded that one of the most effective means of putting an idea across is by word of mouth. All auxiliary members are members of other clubs and organizations and more often than not, are leaders in those groups. Finding themselves in such strategic positions they can do much toward formulating health education programs which will bring true information and correct interpretation of health issues to the entire membership. There is no way of estimating how far reaching the efforts of even one member can be in the influencing and forming of public opinion, when those efforts are exercised in the right direction.

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can avail ourselves. The Bulletin, which is the auxiliary's official publication, should be read and studied by every doctor's wife. The over-all auxiliary program, along with articles on subjects vital to the medical profession and health education in general, are printed in the Bulletin. The American Medical Journal and Hygeia give excellent material on medical issues and information for radio and other better health. We should familiarize ourselves with radio and other programs that can be obtained from the American Medical Association for schools and organizations desiring such material.

Auxiliary members as a whole know that before any project may be launched it must have the approval of the Advisory Council of the medical association, be it county, state or national. The Advisory Council members are busy men. Let us do all we can to interest them in auxiliary work, but at the same time show them every courtesy and consideration possible in appreciation of the time and energy which they so generously give us. They can be an active force in our auxiliary endeavors, whether we are working as an auxiliary or as individuals in other groups. We should solicit their active assistance and interest at all times and not only when a special project has to be considered.

The postwar period will bring many new problems, which cannot be foreseen at this time. We must be ever watchful and alert so that we shall be adequately prepared and able to meet whatever demands are made upon us. May we always hold to the high ideals and true spirit of medicine, and thereby be inspired to do the quality of work which will prove us to be worthy of being a part of such a noble profession.

OUR ADVERTISERS

You, no doubt, have noticed the beautiful advertising which has added to the appearance of our Journal. We are very grateful to these companies for their interest in the Journal, and feel sure that you will avail yourselves of the literature and samples offered by the various companies.

Obituaries

J. M. Bonham, M.D.
1870 - 1945

Dr. James Milton Bonham died July 14, in the hospital at Hobart, following an illness of one week.

Dr. Bonham was born in Osceola, Iowa on May 25, 1870. He attended Kansas City Medical School, graduating second highest in his class in 1901. He came to what is now Hobart on August 4, 1901 and began to practice medicine. He served as an Army Medical officer in World War I; was chairman of procurement and assignment for Army Physicians for western Oklahoma in the present war and examining physician for army inductees.

Dr. Bonham was a member of the Kiowa County Medical Society, the Oklahoma State Medical Association, American Medical Association, and the American College of Surgeons. He was president of the Hobart Country Club, active member of the Chamber of Commerce, Rotary Club and Shrine. He is survived by his son, Dr. William L. Bonham, of Oklahoma City.

The Hobart "Star-Review" of July 19th pays tribute, part of which we quote: "One of this community's modern ties to its colorful beginning and early history was broken last week with the death of Dr. J. M. Bonham.

"To me, Dr. Bonham was Hobart. He has always been identified with the community, from the time he delivered the first baby born here in a tent, down to his efforts toward helping plan for the post-war era. Any project for bettering the community seemed to require and always received his approval and personal cooperative effort. He didn't pass the buck to somebody else. He did the job himself."

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D. F. Stough, Sr., M.D.
1875 - 1945

Dr. Daniel Freeman Stough, Sr. died at his family residence in Geary on Thursday, September 6th. He had been in ill health since he suffered a stroke in 1940.

Dr. Stough was born in LaGrange County, Indiana, on July 25, 1875. He attended Illinois Medical College in Chicago where he received his Medical degree in 1889. In 1909 Dr. Stough moved to Geary where he was a practicing physician until 1940, when ill health compelled him to retire.

He was a member of the Geary Board of Education and its Secretary for a good many years. He also served as City Treasurer several years and was Mayor at the time he became seriously ill. He was active in Masonic circles, being a Thirty-second degree Mason. He was a member of the Blaine County Medical Society, Oklahoma State Medical Association, and the American Medical Association.

Survivors include his wife, Mrs. Myda M. Stough, two sons, Dr. Freeman Stough, Geary and Dr. Austin Stough, McAlester; one daughter, Mrs. Harold Cooksey of Norman.

N. L. Barker, M.D.
1885 - 1945

Dr. Nim Lou Barker, of Broken Bow, died at his home on August 19th. He had been in ill health for some time, but his death was unexpected.

Dr. Barker was born in Harrison, Arkansas, on October 8, 1885. He had practiced medicine in Broken Bow since 1919. He was a member of the McCurtain County Medical Society, Oklahoma State Medical Association and the American Medical Association. He was also a member of the Lions Club, Masons, and the Christian Church.

Survivors include his wife, two sons, one daughter and one brother.

Classified Advertisements

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Book Reviews

THE RELIGIOUS AND PHILOSOPHICAL ASPECTS OF VAN HELMONT'S SCIENCE AND MEDICINE.

Walter Pagel. Supplement to the Bulletin of the History of Medicine. Editor: Henry E. Sigerist. The Johns Hopkins Press, 1944. Price \$1.00. For subscribers to the Bulletin of the History of Medicine, 75c.

This learned philosophical biography of Van Helmont is well worthy of review. Knowledge of the men who have made landmarks in the history of medicine ought to be continually held up before us so that it may stimulate us "to make our lives sublime" as medicine did not spring full grown out of the head of Hippocrates.

Van Helmont had his active period of life when the schism between the time when medical philosophy was dominated by the reasonings of Hippocrates, Aristotle, Galen, et. al., and the period when observation rather than reasoning dominated thinking. It had been heretical to have differed one iota from their teachings. Just before Helmont's birth, Columbus had different ideas of the earth's surface and was bold enough to follow

the courage of his convictions by going on his exploratory voyage. Paracelsus at that time indulged in polemics against the then incontrovertible ideas. Michael Servetus was burned at the stake because of his medical and religious beliefs that were inimical to the then ideas as voiced by John Calvin. The schools then taught in terms of logic and mathematical patterns irrespective of the actual phenomena and observation. He claimed reason was in no sense the highest function of the intellect as he cited in the mentally deficient and in animals, notably foxes outwit their enemies most skillfully. "Much more reliable than the logical conclusion is the knowledge of premises."

The religious motives of skepticism towards complacent human reason are nowhere as clearly expressed and illustrated as by Van Helmont and his work. The substance of pagan philosophy so shamelessly adopted by Christian schools is still more the target of his fiery attacks. "It is the heathen Aristotelian doctrine long ago refuted by St. Paul but stubbornly followed by the schoolmen." Therapy was directed against fictitious humours, elements and qualities. To him life meant a modification of matter which the Creator compels to act in different ways which are different in each human being. It is the Archeus which directs growth and maintains the growth and continuation of living beings. Religious motives led him to skepticism toward human reason also to empiricism as the way of truth and reality. His accomplishments may be summed up: (1) He demonstrated acid to be responsible for digestion in the stomach and alkali for that in the duodenum. (2) Founder of Biochemistry. (3) Measuring time by the pendulum. (4) Founder of Modern Pathology. (5) Folly of catarrh, then the universal explanation of disease.

The author expresses gratitude to Dr. V. C. Robinson, M.R.C.P., for revising the manuscript and suggestions offered. Dr. Robinson, Temple University, has a very scholarly book entitled "Story of Medicine" which should be universally read.—Lea A. Riely, M.D.

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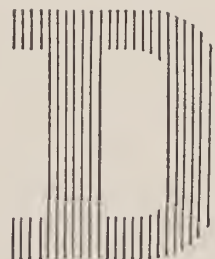
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1. Am. J. Dis. Child. 66:1 (July) 1943.
2. Nebraska State Med. J. 29:15 (Jan.) 1940.

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Medical School Notes

Major Clinton S. Maupin, '34med, has been released from prison camp in Fukuoka, Island of Honshu, Japan. He was taken prisoner during the battle of Bataan.

Major Weldon K. Ruth, '33med, captured with the fall of Bataan in 1942, is safe in the Philippines, arriving there from Formosa.

Captain Neel J. Price, '42med, has served twenty-four months as a Battalion surgeon in the 351st Infantry, with twenty months spent in North Africa and Italy. His decorations include a Bronze Star with one Oak Leaf Cluster, a Purple Heart, a Combat Medical Badge, and a Unit Presidential Citation.

Dr. Gayfree Ellison, '40med, has been discharged from the Army after having been on active duty since November, 1941. He has accepted a position at the Western Oklahoma Hospital, Clinton, Oklahoma.

Captain Vance F. Morgan, '34med, and Lt. Thomas P. Anderson, '43med, graduated from the Army Air Forces School of Aviation Medicine, Randolph Field, Texas, on 15 September 1945.

The Navy V-12 Program at the School of Medicine will be discontinued at the end of the present semester, October 27, 1945. It is anticipated that all Naval students will continue their medical education under the G. I. Bill of Rights.

Recent acquisitions of the School of Medicine Library include:

Armstrong, H. G. Principles and practice of aviation medicine. 2d ed. 1943.

Association for research in nervous and mental disease. Sensation: its mechanisms and disturbances, 1935.

Bailey, Hamilton. Emergency surgery. 1944.

Ball, J. M. Sack-em-up men. 1928.

Bradford, F. K. and Spurling, R. G. Intervertebral disc. 2d ed. 1945.

Brous, Florence. Bibliography and surveys on lead poisoning. 1943.

Critchley, Macdonald. Shipwreck survivors. 1943.

Dandy, W. E. Intracranial arterial aneurysms. 1945.

Draper, George. Human constitution. 1924.

Glasstone, Samuel. Theoretical chemistry. 1944.

Goldzieher, M. A. Adrenal glands in health and disease. 1944.

Gordon, B. L. Romance of medicine. 1945.

Jokl, Ernst. Medical aspects of aviation. 1943.

Kantor, J. L. Synopsis of digestive diseases. 1937.

Matthews, D. N. Surgery of repair. 1943.

Merck & Co., Inc. Penicillin. 1945.

Ratcliff, J. D. Yellow magic. 1945.

Siegler, S. L. Fertility in women. 1944.

Sigerist, H. E. Civilization and disease. 1944.

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The man who wishes to bestow a lasting benefit upon the science, must enter upon the examination of disease with a determination to doubt everything which cannot be proved.—Robert Haxall. *Library of Practical Medicine. Massachusetts Medical Society. Vol. VII. p. 84. 1836.*

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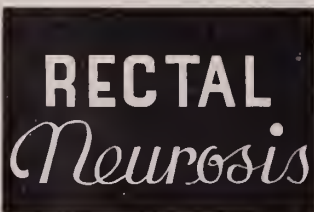
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MEDICAL ABSTRACTS

A NEW TREATMENT FOR ESOPHAGEAL OBSTRUCTION DUE TO MEAT IMPACTION. J. R. Richardson. *The Annals of Otolaryngology, Rhinology, and Laryngology*, Vol. 54, pp. 328-348, June, 1945.

People who have an upper denture occasionally swallow large masses of meat and fish. This occurs most often so that the esophagus will become obstructed. The symptoms of such obstruction come suddenly while a person is eating. The foreign body is lodged low in the esophagus, and the patient can fill his esophagus with fluids, and partially regurgitate the food. Pain may or may not be present.

The meat should be removed. In young persons, morphine sometimes relaxes the normal esophagus sufficiently so that the foreign body slides down into the stomach. If no treatment is given, the meat decays in a period from seven to fourteen days, and, rarely, a spontaneously recovery can occur. Another method is to remove the impacted meat by means of an esophagoscope.

The author suggests the use of a preparation called Caroid. Its chief constituent is papain which is able to digest about 35 times its weight of lean meat. Hourly administration of 15 grains of caroid, and 15 to 40 grains of lactose will be of great help in many cases. It can be given in a little water or in form of a 5 per cent solution. In a series of 17 cases, 16 of the patients were promptly relieved of their obstruction.

The enzyme works best when the obstruction is low in the esophagus. Relief comes within an hour and a

half in many instances; the longest time needed for complete digestion of impacted meat was seven and a half hours.—*M.D.H., M.D.*

AN ANALYSIS OF COLDS IN INDUSTRY. J. H. Kler. *Archives of Otolaryngology*, Vol. 41, pp. 395-407, June, 1945.

The common cold is a health problem that concerns all physicians. It is an ailment that affects virtually every one once each year and there is no time of the year when the community is entirely free of colds. Life in the cities, with its crowded condition, is conducive to the spread of colds. Little scientific knowledge was obtained as to the cause, prevention and cure of colds. Thus, the common cold remains a complex problem, and persists in having serious complications.

The cold problem is of no particular importance in industry. Colds are responsible for more than one-third of the total number of days lost in American industry. They cause a loss of 100 million working days each year. This represents an annual cost of about one or two billion dollars.

The author made a thorough investigation of the cold problem and attempted an objective study. From this investigation the following became evident. Colds have a definite cycle of incidence, with peaks in December and in October, and the lowest point in July. The incidence of colds was constantly higher in Chicago than in the East. Every sudden drop in temperature is followed in a day or two by a rise in the incidence of

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colds. There is no marked correlation with season. In colds lasting more than a week the duration was unaffected by seasonal changes, but the percentage of colds running over three weeks was much higher in the winter months.

The highest incidence of colds was found in the age group 20 to 29 years and the lowest in the age group above 50 years. Also, there were more colds among women than among men, more colds among office employees than among factory employees. Time-losing colds in air-conditioned places were below average except in the summer months. The shipping departments uniformly has a high general incidence of colds. The majority of sickness lasted less than a week. Colds among men lasted longer.

The majority of colds lasting a week or longer started in the head and spread to the throat or chest. There were more colds involving the chest among the men than among the women. Smoking apparently had little effect on colds. Forty-five per cent of those with colds did not smoke at all, 17.4 per cent were light smokers, 31.6 per cent were medium smokers, and 5.6 per cent were heavy smokers.

Menstruation is an important factor in the incidence of colds among women, and important in the increased severity of colds among them. Posture is also important in the incidence and the severity of colds. The incidence was lowest among those whose work necessitates walking about most of the time.

Early therapy seems to be of the greatest value against colds at present.—*M.D.H., M.D.*

PATHOGENESIS OF GLAUCOMA. L. Hess. Archives of Ophthalmology, Vol. 33, pp. 392-396. May, 1945.

Glaucoma does not arise primarily in the eyeball but has its origin in certain nerve structures outside the eye — the ciliary ganglion, the diencephalic vegetative center at the base of the brain in the neighborhood of the optic chiasm, and in the cortex of the brain. The signs of acute and of some types of chronic glaucoma were once considered to be inflammatory. But the classic signs of inflammation cannot be demonstrated.

The sudden attack in glaucoma reminds one of an acute crisis of the vegetative nervous system. The actual site of the crisis in acute glaucoma is the ciliary ganglion and the nerves and capillaries of the ciliary body. It develops there under the indirect influence of the cortex, or under the immediate influence of the diencephalic center, from where the irritation is conveyed to the bulbus by way of certain nerves.

The crisis consists primarily of a vasomotor and secondarily of a secretory disturbance. The crisis is a constrictor one. There is narrowing of the terminal branches of the retinal artery after an attack, a sudden rise of the systemic arterial pressure often antedating the attack, arterial pulsation in the papilla after attack, and impairment of eyesight depending on the ischemia of the retina.

The mydriasis is of sympathetic origin, but all the other signs can be accounted for on a neurogenic basis. The edema of the cornea, and of conjunctive, lids and iris are likewise a nervous effect. One is also confronted with a certain nervous mechanism regulating the production, inflow and outflow of the fluids of the eye.

In the production of the fluids of the eye, two factors are borne in mind; more transudation, largely dependent on the intracapillary pressure in the ciliary processes, and an apparently true epithelial secretion of the ciliary body. The transudation is regulated by nerve impulses. There is no evidence of a primary blockade to the outflow of blood in the onset of glaucoma. The primary disturbance is suggested in the increased production and inflow of fluids.

The regulatory nervous mechanism is a reflex mechanism consisting of a proprioceptive limb, an efferent limb, and a central, ganglionic portion. The efferent limb of this reflex arc is made up of fibers of the ophthalmic division of the trigemini, which are distributed to all

the tissues of the bulbus. The ciliary ganglion is the center for all the nerve impulses arising within the eye. It represents the central portion of the reflex arc.

Another reflex arc is connected with the diencephalic center. Stimulation of this center results in protrusion of the bulbus, maximum mydriasis, widening of the palpebral fissure, lacrimation and pain, i. e., signs associated with glaucoma. The pathways connecting this center with the nerves of the eye are the peduncles, the upper thoracic portion of the spinal cord, and the centrum ciliospinale of Budge. From there, the impulses spread to the ganglion cervicale supremum, to the cavernous and carotid plexuses, and, finally, to the ciliary ganglion.

The third reflex arc is cortical. It is possible that the cortical impulses (anxiety) are carried to the thalamus, and through the thalamus the hypothalamic organ becomes activated.—*M.D.H., M.D.*

REPORT OF FORTY-EIGHT CASES OF MARGINAL BLEPHARITIS TREATED WITH PENICILLIN. M. E. Florey, et. al. The British Journal of Ophthalmology, Vol. 29, pp. 333-338. July, 1945.

Marginal blepharitis is a relatively common and rather intractable inflammation of the lid margins, usually attributed to infection with staphylococcus aureus. Many treatments have been tried in the past, such as application of ointments, of dye solutions, mild antiseptics, and of caustics. Combined with these treatments other measures were also recommended such as epilation of eyelashes, autogenous and stock staphylococcus vaccines, staphylococcal toxoid, correction of errors of refraction, vitamins, and removal of septic foci.

The multiplicity of treatment indicates the intractable nature of the disease. It tends to improve but it usually shows frequent relapses, and may pass easily into the chronic stage which may be life long.

The authors carried out an investigation in order to test the clinical value of penicillin in an established infection due to an organism known to be sensitive to its action. Throughout the investigation clinical signs were correlated with bacteriological findings. The type of blepharitis varied; some of them were of the ulcerative type, others were squamous and one was complicated with corneal ulcers. The duration of the lid disease before treatment varied from three weeks to 32 years.

Staphylococcus aureus was present in 39 cases, staphylococcus albus in two. The treatment was carried out by the patients themselves. They were each given a weekly supply of a few grams of ointment containing 600-800 Oxford units per gram. This was made by dissolving the requisite amount of penicillin in a few drops of sterile distilled water and beating this up, under aseptic conditions, with sterilized vaseline. Each patient was instructed to apply a small quantity of this on the lid margins with a wooden probe, rubbing it in with the latter. This treatment was carried out three times a day and always just before going to bed at night. No adjuvant treatment was given and very few lashes were epilated. Recovery was not considered to be complete until the lids looked normal and no staphylococcus aureus could be cultivated from them a week after penicillin was discontinued.

All patients except one reported alleviation of symptoms and a number stated that their eyes had not been so comfortable for years. Clinical recovery took place in 36 of the cases. Bacteriological recovery was registered in 24 of these. No improvement was reported in one case who had a refractive error and from whose lids no organism but staphylococcus albus was cultured. Mild cases, even when chronic, had recovered with a fortnight's treatment. Some intractable infections recurred after one or two weeks' cessation of treatment.

From this series of cases it seems that penicillin ointment offers a hopeful form of treatment for marginal blepharitis. Most probably better results could have been obtained had all possible foci of reinfection been eradicated.—*M.D.H., M.D.*

EXPERIENCES OF A BLOODLESS TREATMENT FOR RECURRENCE-PARALYSIS. E. Froeschels. *Journal of Laryngology and Otology*, Vol. 59, pp. 347-357. October, 1944.

Paralysis of the recurrent nerve occurs frequently after thyroidectomy. The nerve is not always injured directly. Circulatory disorders are sometimes responsible for the paralysis, and according to recent statistics more than 50 per cent of thyroidectomy show paresis or paralysis of the recurrent nerve after the operation.

The nerve may be affected on one side or on both sides. When the paralysis is bilateral, a fixation of the vocal cords in the median, or in the cadaveric position may present itself. It was believed that the fixation of vocal cords in this position is based on heavier injury to the muscles of the openers. Hence the effort was made to combat the preponderance of the closers by a total resection of the recurrent nerve. Others recommended the total extirpation of the vocal cords.

It has been also suggested that a window be cut into the thyroid cartilage in order to fix one end of the cord on to the musculus stylohyoideus, thus preventing the vocal cord from being drawn toward the middle line during breathing. Another operative method that was recommended proceeded so that after splitting the thyroid cartilage, a piece was clipped off, and sewed wedge-like into the front part of the glottis. Others attempted a neurotization of the cricoarytenoid muscle by connecting it with the omohyoid muscle.

The most recent method is that proposed by King. In this operation the cricoarytenoid joint is disarticulated, and the arytenoid cartilage displaced outward by a suture which surrounds the cartilage submucously, and is passed through the lateral border of the thyroid cartilage. The omohyoid muscle is attached to the arytenoid cartilage for the purpose of further opening the cords during the inspiratory efforts.

Recent findings suggest that the superior laryngeal nerve is a motor nerve. There is much probability, therefore, that cases of paralysis of the recurrent nerve can be cured or improved by special type of training, no matter how long the paralysis has existed. The method recommended by the author is what he calls "pushing exercises."

These exercises are carried out as follows. When standing in a manner that permits elasticity of the body the patient should energetically push his clenched fists from the chest as far downwards as possible. It is necessary to make the downward movement so that the fists are finally close to the front of the thighs. Special attention must be paid so that no stiffening in the joints involved occurs before the fists have reached the lowest possible line, i. e., the elbows as well as the wrists should be entirely stretched at the end of the pushing.

If the patient is able to perform all, he should be asked to emit a vowel exactly synchronic with the downward pushing of his fists. Neither should the vowel appear before the fists are on their way down nor after they have reached the lowest point. The smallest deviation from these demands renders the whole method ineffective. The exercise should be executed for half a minute to a minute not less than twenty times a day.—*M.D.H., M.D.*

HEMANGIOMA OF THE EAR: A NEW METHOD FOR THE CONTROL OF HEMORRHAGE. O. J. Dixon. *The Annals of Otology, Rhinology, and Laryngology*, Vol. 54, pp. 415-420. June, 1945.

Profuse and unexplained hemorrhage from the external auditory meatus always indicates some vascular anomaly within the mastoid process or the middle ear. The author reports two cases of hemangioma of the ear in which the tumor was cause of a rather uncontrollable bleeding.

In one patient, during the course of the operation, it became necessary to immediately control bleeding.



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In the second patient the bleeding was under control until the antrum was opened. Since the area of bleeding was small, tissue flap was used for controlling the hemorrhage. Muscle flap was prepared, since such a viable tissue promotes the processes of coagulation rapidly, and will permanently remain in place. In the second case, therefore, sound healing was permanent without secondary infection.

The second patient suffered also from deafness due to the hemangioma. After the operation there was an unexpected but complete restoration of hearing in the operated ear.—M.D.H., M.D.

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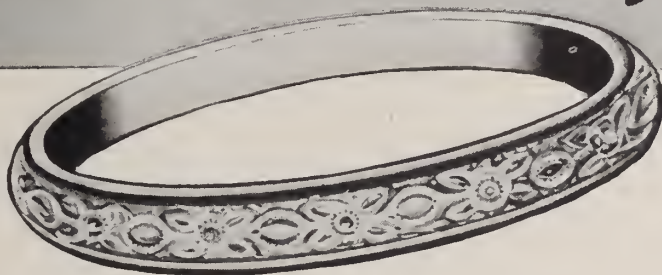
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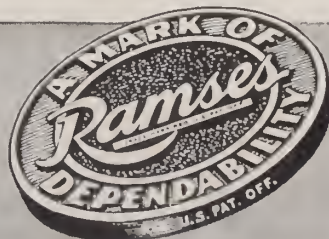
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Beckham.....	G. H. Stagner, Erick	O. C. Standifer, Elk City	Second Tuesday
Blaine.....	Virginia Curtin, Watonga	W. F. Griffin, Watonga	
Bryan.....	W. A. Hyde, Durant	W. K. Haynie, Durant	Second Tuesday
Caddo.....	C. B. Sullivan, Carnegie	P. H. Anderson, Anadarko	
Canadian.....	P. F. Herod, El Reno	A. L. Johnson, El Reno	Subject to call
Carter.....	J. L. Cox, Ardmore	H. A. Higgins, Ardmore	Second Tuesday
Cherokee.....	P. H. Medearis, Tahlequah	W. M. Wood, Tahlequah	First Tuesday
Choctaw.....	O. R. Gregg, Hugo	E. A. Johnson, Hugo	
Cleveland.....	Iva S. Merritt, Norman	O. M. Woodson, Norman	Thursday nights
Comanche.....	W. F. Lewis, Lawton	W. C. Cole, Lawton	
Cotton.....	G. W. Baker, Walters	Mollie F. Scism, Walters	Third Friday
Craig.....	Lloyd H. McPike, Vinita	J. M. McMillan, Vinita	
Creek.....	C. R. McDonald, Mannford	Philip Joseph, Sapulpa	
Custer.....	T. A. Boyd, Weatherford	W. H. Smith, Clinton	Third Thursday
Garfield.....	P. W. Hopkins, Enid	John R. Walker, Enid	Fourth Thursday
Garvin.....	Marvin E. Robberson, Wynnewood	John R. Callaway, Pauls Valley	Wednesday before Third Thursday
Grady.....	Roy E. Emanuel, Chickasha	Rebecca H. Mason, Chickasha	Third Thursday
Grant.....	I. V. Hardy, Medford	F. P. Robinson, Nash	
Greer.....	R. W. Lewis, Granite	J. B. Hollis, Mangum	
Harmon.....	W. G. Husband, Hollis	R. H. Lynch, Hollis	First Wednesday
Haskell.....	William Carson, Keota	N. K. Williams, McCurtain	
Hughes.....	H. A. Howell, Holdenville	Imogene Mayfield, Holdenville	First Friday
Jackson.....	C. G. Spears, Altus	E. A. Abernethy, Altus	Last Monday
Jefferson.....	F. M. Edwards, Ringling	J. I. Derr, Waurika	Second Monday
Kay.....	Dewey Mathews, Tonkawa	G. H. Yeary, Newkirk	Second Thursday
Kingfisher.....	B. I. Townsend, Hennessey	A. O. Meredith, Kingfisher	
Kiowa.....	J. P. Braun, Hobart	William Bernell, Hobart	
LeFlore.....	Neeson Rolle, Poteau	Rush L. Wright, Poteau	
Lincoln.....	U. E. Nickell, Davenport	C. W. Robertson, Chandler	First Wednesday
Logan.....	J. L. LeHew, Jr., Guthrie	J. E. Souter, Guthrie	Last Tuesday
Marshall.....	J. L. Holland, Madill	J. F. York, Madill	
Mayes.....	S. C. Rutherford, Locust Grove	B. L. Morrow, Salina	
McClain.....	J. E. Cochrane, Byars	W. C. McCurdy, Jr., Purcell	
McCurtain.....	J. T. Moreland, Idabel	R. H. Sherrill, Broken Bow	Fourth Tuesday
McIntosh.....	J. Howard Baker, Eufaula	Wm. A. Tolleson, Eufaula	First Thursday
Muskogee-Sequoyah			
Wagoner.....	H. A. Scott, Muskogee	D. Evelyn Miller, Muskogee	First Monday
Noble.....	D. F. Coldiron, Perry	Jess W. Driver, Perry	
Okfuskee.....	W. P. Jenkins, Okemah	M. L. Whitney, Okemah	Second Monday
Oklahoma.....	Gregory E. Stanbro, Okla. City	Ben H. Nicholson, Okla. City	Fourth Tuesday
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Osage.....	G. K. Hemphill, Pawhuska	C. R. Weirich, Pawhuska	Third Monday
Ottawa.....	P. J. Cunningham, Miami	L. P. Hetherington, Miami	Second Thursday
Pawnee.....	E. T. Robinson, Cleveland	R. L. Browning, Pawnee	
Payne.....	Haskell Smith, Stillwater	A. C. Reding, Stillwater	Third Thursday
Pittsburg.....	L. N. Dakil, McAlester	A. R. Stough, McAlester	Third Friday
Pontotoc-Murray.....	Ollie McBride, Ada	R. H. Mayes, Ada	First Wednesday
Pottawatomie.....	Chas. W. Haygood, Shawnee	Clinton Gallaher, Shawnee	First and Third Saturday
Pushmataha.....	John S. Lawson, Clayton	B. M. Huckabay, Antlers	
Rogers.....	K. D. Jennings, Chelsea	Chas. L. Caldwell, Chelsea	Third Wednesday
Seminole.....	A. A. Walker, Wewoka	Mack I. Shanholtz, Wewoka	Third Wednesday
Stephens.....	W. K. Walker, Marlow	E. H. Lindley, Duncan	
Texas.....	R. G. Obermiller, Texhoma	Evelyn Rude, Guymon	
Tillman.....	W. A. Fuqua, Grandfield	O. G. Bacon, Frederick	
Tulsa.....	H. A. Ruprecht, Tulsa	E. O. Johnson, Tulsa	Second and Fourth Monday
Washington-Nowata.....	J. V. Athey, Bartlesville	S. A. Lang, Nowata	Second Wednesday
Washita.....	A. S. Neal, Cordell	James F. McMurry, Sentinel	
Woods.....	O. E. Templin, Alva	I. F. Stephenson, Alva	Last Tuesday
Woodward.....	Roy Newman, Shattuck	C. W. Tedrowe, Woodward	Odd Months Second Thursday

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Benign Esophageal Strictures

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Benign esophageal strictures are so called to distinguish them from those esophageal narrowings caused by neoplastic disease. They are caused primarily by cicatricial contracture of the esophageal wall as a result of injury and healing processes. These injuries are caused most frequently by corrosive chemicals, at times by foreign bodies, by instrumental trauma, by ulceration from severe infections such as typhoid fever and by peptic ulcer. Household lye, which is composed of 95 per cent sodium hydroxide, is by far the most common causative agent. Other strong washing powders, household ammonia and various acids are at times encountered. Solution of lye are used for soap making and for other household purposes. Small children attempt to drink such solutions or find the dry powder and mistake it for sugar. Adults at times ingest these caustic substances by mistaking them for some medication and at times attempt suicide by purposeful ingestion.

Solutions of lye burn immediately on contact with mucous membranes. First aid measures, such as dilute vinegar or lemon juice with large amounts of water, must be administered very quickly to appreciably limit the extent of the injury. By the time the doctor sees the patient the damage has already been done. Immediate treatment can then be only palliative and supportive.

The burns involve the mouth, pharynx, esophagus, and sometimes the larynx. There is intense swelling and profuse exudation. It is difficult for the patient to expectorate, and difficult or impossible for him to swallow. There may be profound shock as from any

other severe burn. The local lesions progress to sloughing and ulceration. Secondary infection is very likely to cause increased tissue damage and prolong the healing period. Under supportive therapy the acute edema usually subsides in a short time so that the patient can swallow liquids. He may then get along fairly well for from two weeks to two months when swallowing becomes more difficult or even impossible because of secondary closure of the esophageal lumen. The ulcerations may be healing and the closure be caused by fibrosis and contracture. Secondary infection may have caused increased swelling, granulations, and even further extension of the tissue damage. This will of course eventually result in more extensive fibrosis as healing occurs. As fibrosis proceeds the scar tissue becomes more dense and the involved areas more rigid and inelastic.

Treatment must be directed first toward preserving the life of the patient, second toward maintaining his general state of health so that he may heal his lesions, third toward maintaining a patent esophageal lumen and lastly toward restoring this lumen to a size compatible with relatively normal esophageal function.

If the patient is in shock he must be treated generally for shock as in any serious injury. Once the shock is under control or if the patient is not in shock, other measures should be used. Parenteral fluids are usually necessary to maintain fluid balance and prevent acidosis. If there is definite laryngeal obstruction tracheotomy may be necessary. The use of gentle mechanical suction to remove profuse secretions from the mouth and throat is very helpful. Keeping the mouth

clean not only makes the patient more comfortable but helps prevent stagnation of infected mouth secretions. Measures such as penicillin and the sulfanomides to prevent secondary infection are of definite value. If the patient does not begin to swallow liquids within a very few days the performance of a gastrostomy will make possible the maintenance of nutrition.

If the patient can be persuaded to swallow a thread and to let the thread remain in place he will never develop a complete occlusion of his esophagus. Attempts to keep the esophageal lumen open by the use of catheters, Levine tubes, or bougies during the stage of acute ulceration are at times successful but are dangerous and add an element of trauma to the already present pathology. Attempts to gain and maintain a large lumen during the acute ulcerative stage are not only extremely dangerous but are very likely to cause more inflammation and actually make the condition worse rather than better. Healing is extremely slow. Infection from the mouth, irritation and infection from stasis of food in the stricture and in the often dilated area above the stricture along with the factor of trauma from attempts to keep the esophagus open all contributive to delayed healing.

Estimation of the degree of damage to the esophagus and of the extent of healing is made by x-ray study and by esophagoscopy. The latter must be done very cautiously and usually on the most proximal portion of the involved area can be visualized. X-ray studies enable a fairly good evaluation of the extent and location of the often multiple strictures.

Once the patient has recovered from the acute esophageal injury and the ulcerations are healed or nearly so the problem of obtaining and maintaining an adequate esophageal lumen must be considered. The decision as to when to start dilatation is a difficult one and must be made only after consideration of all features in each individual instance.

Dilatation of the strictured esophagus is obtained by passages of bougies through the esophagus in gradually increasing sizes. Eventually almost all cases can be restored to practical function. Except for very mild injuries a lumen of normal size and flexibility is rarely attained. These patients have a handicap of greater or lesser degree and must be very careful in their eating habits for the remainder of their lives. The increase of lumen gained by bouginage is obtained by stretching of the least scarred part of the esophageal wall in the strictured area. A completely annular stricture is extremely difficult to stretch. Naturally to obtain any

stretching at all a considerable amount of force must be used. If too much force is used the esophagus may be ruptured. If not enough force is used no dilation is obtained. It may very easily be understood that treatment of these patients must be carried out for many months.

There are several methods of dilatation commonly used. The most easily used is simple peroral passage of bougies made for use in the esophagus. It is rightly called "blind bouginage" in that the operator cannot see that the bougie is engaged in the lumen of the stricture. There is usually a dilated area above the stricture and this is often sacculated with the small lumen lying on the side wall of the sacculatation. A blindly inserted bougie is apt to impinge on the thin wall of the sacculatation rather than in the lumen and if an appreciable amount of force is used perforation will result. This method is the least effective and the most dangerous of any under consideration. It is responsible for Trousseau's statement years ago that the majority of these patients eventually died of the bougie.

Peroral passage of bougies through an esophagoscope is used in clinics where facilities and trained personnel are available to perform frequent esophagoscopies. The highest stricture may be visualized and the tip of the bougie may be seen to enter its lumen. Theoretically the highest stricture is dilated in this manner until the esophagoscope may be passed through it and the next stricture visualized. Successive strictures are then treated in a similar manner. Practically, this method is blind bouginage after the bougie enters the proximal stricture.

A method used almost entirely in several excellent clinics is the passage of bougies over a string which the patient has swallowed. If sufficient string is swallowed to pass well in to the small intestines it may be drawn sufficiently taut so that a bougie passed downward over it will be certain to engage in the lumen of whatever passage is present through the esophagus. This is a very effective method of dilatation and is very much less dangerous than those previously mentioned. In our hands it has been used only occasionally because we have been unable to persuade our patients to swallow threads.

The fourth method of dilatation was devised by Dr. Gabriel Tucker and is known as retrograde bouginage. It necessitates a large gastrostomy, drawn through the gastrostomy and upward through the esophagus by a string. The patient wears the string continually, one end being brought out through the abdominal wall, the other through the nose and the ends tied together. The operator can

safely use more dilating force in drawing a bougie through an esophagus than in pushing one through. The bougies are so constructed that when traction is made upon them they become very slightly smaller in diameter. Hence they exert an expansile dilating force when drawn into a stricture and left in place for a short time. The original insertion of the string through the esophagus sometimes requires retrograde esophagoscopy through the gastrostomy and the passage of a small bougie upward from the stomach through the esophagus. Sometimes the patient will swallow the string and it may be then fished out of the stomach.

A word about gastrostomy seems in order. In some large clinics gastrostomy is very rarely used. Years ago in our own clinic gastrostomy was often done to prevent starvation of the patient but was not used to assist in dilatation. When the esophagus was sufficiently open to allow swallowing of liquids the gastrostomy was allowed to close. Several of our patients had two gastrostomies and one had three during the course of treatment. We advocate early gastrostomy when the patient cannot or will not swallow a thread. It allows early feeding of a seriously injured patient and the maintenance of a favorable state of nutrition. By freeing the injured esophagus from the irritation of necessary passage of food it allows earlier healing of the local lesions. Lastly it enables us to use the most effective and least dangerous of the methods of dilatation.

The duration of the period of treatment varies greatly. The extent of the original burn, how much delay in healing has been caused by infection and irritation by food and instrumentation, the general health level which can be maintained and the emotional attitude of the patient are all factors which influence the rapidity with which the eventual end result may be attained. The emotional state of the patient and its effect upon spasm of the esophageal musculature constitutes a minor but definite factor in the course of treatment. A patient who is greatly distressed by each successive treatment will not relax during treatment and will have much more difficulty swallowing between treatments than a less emotional patient with the same sized esophageal lumen. The factor of esophageal spasm is often responsible for stasis of food particles within the esophagus and consequent irritation.

These patients are all better cared for in institutions where facilities have been organized and personnel trained for their treatment. Long periods of hospitalization and return visits over a long period of time are necessary. This has long been recognized as

a disease of the poor and the financial resources of the families concerned are rarely able to undertake such long drawn out expense. Attempts to hurry the treatment in the interest of the patient's financial condition are apt to be disastrous. Hence the great majority of these patients are cared for in clinics and properly so.

We have studied the records of 52 patients who have suffered burns of the esophagus and who have been under treatment since 1929. These records have been tabulated under the following headings: (1) age of the patient at the time of injury; (2) time interval between the injury and admission for treatment; (3) whether gastrostomy was performed and how many gastrostomies were performed upon that patient; (4) the method of dilatation used and the period of time during which each method was used; (5) the largest size of bougie attained in the treatment of that patient with each method employed; (6) total period of time the patient was under treatment; (7) result when such information was available from the records, and pertinent comments. This tabulation is included for study by readers who may be interested.

There were no patients under one year of age. Apparently only those babies old enough to be ambulatory are able to get lye solutions. However, over one-half the patients were three years of age or younger. This, of course, indicates that the burden of prevention of such accidents falls upon the parents and upon those responsible for the education of the parents. About one-fourth of the patients were over ten years of age. It could not be determined from the records what proportion were burned accidentally and what proportion with suicidal intent.

The time interval between injury and admission for treatment varied between one day and four and one-half years. Only five patients were seen in less than three weeks after injury.

Gastrostomies were performed upon 38 patients. In the earlier cases in the series gastrostomies were done for feeding purposes only and peroral bouginage carried out without a guiding thread. As soon as the patient could swallow liquids easily the esophagus was allowed to close. One of these early patients had three gastrostomies, the last being left open permanently because her esophagus had become completely occluded after seven and one-half years of treatment. Another patient had a gastrostomy for feeding which was allowed to close after less than a year. She was treated by direct bouginage for eight years though only a size 22 (Fr.) bougie was attained. Then, because of difficulty in maintaining nourishment, she had a

Case	Age	Time before treat. started	Gastro-stromy	Dilatations D=direct R=retrograde & duration	Largest size bougie (Fr.)	Total time under treat.	Result and Comment
1. J. B.	3 yr.	3 days	no	D 4½ yr.	14 No gain made	5 yr.	Cicatricial web above epiglottis. Finally surgical removal of web.
2. B. C.	23 mo.	9 wks.	yes three	D only	24	7½ yr.	Esoph. completely closed 14 yr. after injury.
3. V. M. R.	3 yr.	6 mo.	yes two	D 8 yr. R 3 yr.	22 40	11 yr.	Eccentric stricture and sacculation. Finally opened by retrograde.
4. J. S.	2 yr.	2 mo.	no	D 8 yr.	28	8 yr.	Foreign body incidental 4 yr. after injury.
5. E. L.	2 yr.	5 wks.	yes	D 3 mo. R 1 mo. D 4 mo.	16 16 16	8 mo.	Perforated. Died 4 mo. after closure of gastrostomy.
6. S. W.	15 mo.	16 days	yes	R 7 mo. D 3 mo.	30 28	10 mo.	Perforated. Died 3 mo. after closure.
7. R. R.	2 yr.	2½ mo.	no	D 15 mo.	16	15 mo.	
8. L. T.	6 yr.	2 yr. 14 yr.	no no	D 1 mo. D 1 yr.	30 38	1 mo. 1 yr.	Returned with foreign body 12 yr. after, then treated for 1 year.
9. B. S.	2 yr.	3 wks.	no	D 2 only	17	1 mo.	Perforated. Died.
10. D. M.	22 mo.	9 mo.	no	D 6 wks.	24	6 wks.	Returned with foreign body 2 yr. after and died during extraction.
11. W. Me.	3 yr.	3 mo.	yes	D 4½ yr.	30	4½ yr.	Gastrostomy for feeding only, closed 2 yr. later.
12. B. Mc.	16 yr.	2 mo.	yes two	D 15 mo. R 13 mo. D 7 mo. R 11 mo.	18 26 13 22	4 yr.	No followup. Apparently still has gastrostomy.
13. F. J. F.	18 mo.	2 mo.	yes	D 15 mo.	24	?	Gastrostomy, feeding only.
14. J. R. M.	23 mo.	7 mo.	yes	D 7½ yr.	34	7½ yr.	Gastrostomy, feeding only.
15. J. A.	17 yr.	3 wks.	yes	D 3 mo.	22	?	Gastrostomy for feeding only.
16. D. R.	8 yr.	1 yr.	yes	R 16 mo.	28	6 mo.	Gastrostomy elsewhere.
17. F. E.	2 yr.	6 mo.	yes	none		9 mo.	Complete closure. Died of inanition.
18. R. G. S.	3 yr.	2 mo.	no	D 2 yr.	?	2 yr.	Perforated. Died.
19. W. H.	19 yr.	6 wks.	yes	D 6 mo. R 11 mo. D 12 mo. R 45 mo.	10 28 24 40	8 yr.	Uses mercury bougie at home since discharge.
20. B. C.	23 yr.	6 mo.	yes	R 18 mo.	32	18 mo.	3 yr. later took 40 direct bougie easily.
21. F. P.	17 mo.	7 mo.	no	D 3 yr.	36	3 yr.	
22. W. O.	11 yr.	4 yr.	yes	R 29 mo. D 2 yr.	40 36	6 yr.	Perforated 3½ yr. after tr. started. Operated, recovered. Well.
23. B. B.	3 yr.	4 mo.	yes	R 2½ yr. D 1½ yr.	40 38	4 yr.	Foreign body removed 2 yr. after discharge.
24. J. C.	3 yr.	3 mo.	yes	R 2 yr. D 3½ yr.	40 38	6½ yr.	
25. M. J.	2 yr.	6 wks.	Ref.				Perforated elsewhere. Died of mediastinitis.
26. W. M.	3 yr.	5 mo.	yes	R 6½ yr. D 1 yr.	40 28	7½ yr.	Still under treatment.
27. J. G. B.	37 yr.	1 mo.	yes	R 15 mo.	36	15 mo.	No record of closure of gastrostomy.
28. G. P.	20 yr.	6 wks.	no	D 1 mo.	32	1 mo.	Apparently relieved.
29. C. W. C.	4 yr.	6 wks.	no	D 15 mo.	36	15 mo.	Apparently relieved.
30. B. S. L.	19 yr.	11 mo.	yes	R 21 mo. D 4 mo.	40 40	3 yr.	Followup 14 yr. after injury, well.
31. M. V. K.	23 yr.	3 wks.	no	D 9 mo.	50	9 mo.	Apparently relieved.
32. E. J. S.	7 yr.	2 mo.	yes	D 5 mo. R 3 yr. D 26 mo.	14 40 40	5½ yr.	Tip of bougie lost in stomach. Removed by 2nd Gastrostomy.

Case	Age	Time before treat. started	Gastro-stomy	Dilatations D=direct R=retrograde & duration	Largest size bougie (Fr.)	Total time under treat.	Result and Comment
33. A. G.	4 yr.	3 mo.	yes	R 22 mo.	40	2 yr.	Apparently relieved.
34. E. M. F.	4 yr.	1 wk.	yes	R 15 mo. D 1 yr.	40	2½ yr.	Had pyloric obstruction. Gastrojejunostomy relieved.
35. H. W.	2 yr.	6 wks.	yes	D 1 only		2 mo.	Perforated. Died on first dilatation.
36. E. L.	51 yr.	1½ yr.	yes	R 28 mo.	40	2½ yr.	Apparently relieved.
37. A. F.	18 mo.	7 wks.	yes	R 5 yr.	38	5 yr.	Apparently relieved.
38. E. R. H.	2 yr.	5 wks.	yes	D 1 only		3 wks.	Perforated. Died on first dilatation.
39. M. A.	38 yr.	4 yr.	yes	R 3 yr.	40	3½ yr.	Apparently relieved.
40. P. L.	2 yr.	4 wks.	yes	R 2½ yr.	36	3 yr.	Apparently relieved.
41. B. M.	6 yr.	4½ yr.	yes	R 4½ yr.	38		Still under treatment.
42. V. S.	2 yr.	1 mo.	no	D 4 yr.	38		Still under treatment.
43. A. P.	2 yr.	5 wks.	yes	R 4 yr.	38		Still under treatment.
44. E. D.	1 yr.	1 mo.	yes	R 28 mo.	32	2½ yr.	Apparently relieved.
45. M. A. G.	16 yr.	3 wks.	yes	R 9 mo.	24	9 mo.	Still under treatment elsewhere.
46. E. T. F.	19 yr.	6 wks.	yes feed.	D 4 yr.	31	4 yr.	Permanent gastrostomy. Has occasional dilatation over swallowed thread.
47. D. R.	2½ yr.	1 day	yes	none		3 mo.	Throat burned, healed without stricture.
48. L. S.	18 mo.	2 mo.	yes	R 1 mo.	20	3 mo.	Perforated. Died. Retrograde bouginage.
49. E. G.	23 mo.	2½ mo.	yes	R 20 mo.	38		Still under treatment.
50. M. M.	15 yr.	3 wks.	yes	R 1 mo.	18		Treat. started here, to continue elsewhere.
51. Z. M. V.	5 yr.	1 yr.	yes	R 13 mo.	22		Still under treatment.
52. C. M.	23 mo.	3 mo.	no	D 1 only	26	2 days	Perforated. Died on first dilatation.

second gastrostomy and was started on retrograde dilatations. After three additional years of treatment she took a size 40 bougie both perorally and by the retrograde route and was finally dismissed after surgical closure of the gastrostomy. Of 11 patients who had gastrostomies before 1933 only five were treated by retrograde dilatation. One recent patient had a very severe burn of the mouth and throat and had a gastrostomy for feeding. Her burns healed without stricture formation and she needed no dilatation at all.

Twenty-one patients were treated by direct bouginage only. Usually the bougie was passed through a laryngoscope or esophagoscope with visualization of the proximal stricture. Frequently after initial visualization of the stricture simple blind bouginage was employed. Seventeen patients were treated by retrograde dilatations only. Eleven patients were treated by both methods. Three of the series had no dilatations. One of these had complete closure of the esophagus before admission, one healed without stricture formation and the third had been perforated before admission and died.

The size of bougie attained varied greatly. Some of the early patients were dismissed when they could take a size 20 bougie without difficulty. Recently we have considered it proper to close a gastrostomy when a patient has been taking sizes 34 to 40 read-

ily for several months and when a bougie nearly that large could be passed easily by mouth. Several of the patients now under treatment are ready for closure of their gastrostomies.

Many of these patients are treated over long periods of time. If we exclude those who died before treatment had gotten under way the average for the series is just over forty months. The average duration for the seven patients who are still being treated is the same. The longest duration was eleven years for patient No. 3. Eleven patients were treated over five years each. It is not necessary to hospitalize the patients continuously for such long periods. The initial period of hospitalization is usually long and some patients need to be in-patients each time they return for treatment. Most of them are treated as out-patients and come in at intervals of one to four weeks. Irregularity of attendance of course is a factor and probably prolongs the total period of treatment.

Eleven patients, just over 21 per cent, of the series died while under observation. One of these died of pneumonia three months after the gastrostomy had been closed but while he was still being treated by direct bouginage. Undoubtedly the esophageal difficulty was at least a contributing factor. One patient who was admitted sixteen months after injury with complete closure of the

esophagus died of inanition nine months later. A third patient died on attempted extraction of an esophageal foreign body two years after he had been dismissed from treatment of the stricture. Eight patients, 15.3 per cent, died of perforation of the esophagus by bougies. Four of these were perforated on the first attempt to get a bougie through their esophagus. One was perforated on the second attempted bouginage, one after eight months of treatment and one after two years of treatment. These seven were the result of direct bouginage. Only one patient was per-

forated under retrograde bouginage, this at the fourth treatment by this method. We feel that at least a portion of this mortality might have been avoided if early gastrostomies had been done and no attempt made to dilate the esophagus until healing of the ulcerations had taken place.

Approximately 75 per cent of patients are eventually relieved of obstructive symptoms. They lead normal lives and, except that they must be very careful to masticate their food thoroughly, get along very well.

Amino Acids--Their Clinical Indications And Uses

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The concepts of essential amino acids we owe largely to Rose and his co-workers. Although Willcock and Hopkins, and Osborne and Mendell had previously demonstrated that certain amino acids were essential to life, it was Rose, probably more than anyone, who established the fact that protein per se is not a necessary dietary constituent, but that the building stones of protein, the amino acids, can serve to meet all the body's requirements for protein anabolism. Furthermore, he and others established the fact that of the 23 amino acids, somewhere between 8 and 10 specific ones are essential, i. e., they cannot be synthesized from other constituents in sufficient amount to meet body requirements.

Over ten years ago, Rose prophesied that amino acid preparations would be developed which could be administered parenterally and which would be sufficient in themselves to supply the basis for adequate protein metabolism. Today such preparations are available and provide a most effective means for treating certain types of malnutrition for which formerly there was no specific therapy. In our present day enthusiasm for vitamins and the wholesale application of vitamin therapy as a prophylactic or tonic, or for so-called sub-clinical deficiencies, there has been a tendency to minimize the importance of protein deficiency. The effects of protein deficiency and the frequency of its occurrence must not be minimized.

Protein affects both quantitatively and qualitatively the regeneration and repair of tissue as illustrated by the facts that: hypoproteinemia is an important cause of delay-

ed wound healing and wound dehiscence¹; the liver exhibits an increased susceptibility to injury by such toxic substances as chloroform and arsphenamine during protein depletion — feeding of protein exerts a marked protective action against such injury^{2 3 4}. The starvation that results from protein deficiency even in the presence of adequate dietary carbohydrates, fats, vitamins and minerals has been proved experimentally many times and its effects in human beings are well illustrated by the thousands of starving persons in war-ravaged Europe and Asia. Cannon and his co-workers^{5 6} have shown that the synthesis of antibody globulin depends upon an adequate supply of protein and that in conditions of protein depletion, the body is robbed of one of its most important defense mechanisms against infectious disease — the ability to develop immunity. This explains the well-known trilogy of War, Famine and Pestilence. Unfortunately, one need not travel to war-ravaged countries in order to study the effects of protein depletion; our hospital wards contain many excellent examples and far too often post-mortem examination provides an excellent opportunity for the final analysis of the condition.

Often patients who are suffering from protein deficiency, or in whom such a condition is impending, cannot take adequate amounts of protein by mouth, and it is under these conditions that the use of amino acids, as a nutritive "protein" substance, should be considered specific:

1. There may be a mechanical or functional barrier somewhere in the gastrointestinal tract; a stricture, obstructing

tumor mass, paralytic ileus or perhaps a portion of stomach or intestine which has recently been subjected to some surgical procedure and which must be protected from trauma.

2. Digestive disturbances may prevent assimilation of ingested protein as in severe diarrheas, ulcerative colitis, pancreatic deficiency, etc.
3. Anorexia may prevent an adequate oral intake of protein.

Association with these conditions and adding insult to injury, there is often a marked increase in protein requirements, either from abnormal loss of protein as in chronic proteinuria, draining fistulae, or large exuding wounds, or from increased metabolism, occasioned by fever, regeneration of tissue, etc. Parenteral therapy to relieve protein deficiency is of special importance in preparation of patients for operative procedures, as well as in helping to maintain their nutritional state during the early postoperative period. In a discussion of hypoproteinemia and its relation to surgical problems, Ravdin states,⁷ "No consideration of fluid or electrolyte loss and their restitution is sufficient unless the plasma protein is simultaneously considered." Many surgeons do not sufficiently appreciate the fact that the degree of hypoproteinemia in surgical patients and the incidence of operative mortality closely parallel each other.

Certainly the indications for, and valuable aid to be derived from amino acid therapy are not confined to the field of surgery; any condition in which hypoproteinemia exists or is imminent and in which for any reason adequate protein cannot be taken by mouth or assimilated in the usual manner is positive indication for amino acid therapy. These include such conditions as nephrosis, and Farr⁸ has reported marked decrease in mortality in the nephrotic crisis, entirely, he says, from the administration of amino acids parenterally. Recently, Madden and Whipple presented detailed nitrogen balance studies on a patient with chronic ulcerative colitis, who had failed to respond to many varied and intensive therapeutic measures and who had been given a hopeless prognosis. At this late stage intensive amino acid therapy was begun. The patient not only improved but appeared, at the end of about eight months, to have completely recovered. Dysentery, typhoid fever, and other severe diarrheas, celiac disease, fibrocystic diseases of the pancreas, sprue and other conditions of similar nature also present a therapeutic problem in which adequate nutrition, especially of protein, is of paramount importance. In a recent report of the Committee on Convalescence and Rehabilitation of the National Re-

search Council (Feb. 1944) it is stated: "As soon as injury or disease occurs, malnutrition almost always begins. This is the result of two processes: first 'toxic destruction of protein' i. e., the direct effect of disease or injury in promoting destruction of tissues; second, diminished intake of food, because of inability or disinclination to eat. Both of these processes bear some relation to the severity of the injury or disease.

"Although some wastage of tissues can be tolerated and has not easily demonstrable effect on strength and efficiency, the extent of such 'harmless' deficiency is ill-defined. There is ample evidence that any considerable nutritional deficiency is distinctly harmful: it first reduces tolerance for exceptional exertion; in its most severe form it is altogether incapacitating. Even a mild degree of malnutrition should, therefore, be prevented because, though its evil effect may be undetectable, it marks a step toward incapacity and each step makes physical efficiency more precarious.

"The 'toxic destruction of protein' can be alleviated only by effective treatment of the disease or injury from which it originates. Its evil effects are, however, exaggerated by inadequate dietary intake. Wasting from this cause can be prevented in a large proportion of patients, and even 'toxic destruction of protein' may be reduced by the effective administration of fluid and food in proper quantities and proportions. In addition, by improving the general state of health these measures promote and shorten the processes of repair."

Amino acid mixtures are prepared in two principal ways: (1) purified individual amino acids, either natural or synthetic, may be combined in proper proportions to give a balanced mixture; (2) a nutritionally complete protein may be broken down, through hydrolysis, to its amino acid components. At present the latter type of preparation is the most practical one and is the only type which is available commercially. Casein, because of its high quality, nutritionally speaking, its availability and relatively low cost, has been most used to furnish amino acid mixtures of this type. Many new products of similar nature are, however, in the process of development, using other native proteins such as beef plasma as their source.

Protein hydrolysis may be accomplished in three principal ways: by the use of enzymes, acid or alkali. Probably the best amino acid preparation on the market today is a product of enzymatic hydrolysis. By this process none of the amino acids is lost and, as has been repeatedly shown, this product is essentially equal in nutritive value to the casein from which it was made. The disadvantage of this

method lies in the fact that enzymatic processes are inconstant and exact duplication of the process from time to time is very difficult to attain. Acid hydrolysis, though a much simpler process, results in an almost complete destruction of one of the essential amino acids, tryptophan, so that to restore the nutritive properties of this hydrolysate, tryptophan must be added; this adds greatly to the cost. Alkaline hydrolysis has not been used extensively in the past for preparation of amino acids for parenteral injection because with alkaline hydrolysis there occurs racemization which results in very toxic products.

Experimental and clinical studies to evaluate possible toxic effects from protein hydrolysates have been quite extensive and the following conclusions have been reached:⁹

1. Amino acid mixtures, if properly prepared, are not antigenic and allergic reactions following their injection do not occur.*
2. If amino acids are properly administered, with special regard to the concentration and rate of administration if given parenterally, significant reactions are not encountered.
3. There is no evidence of harmful piling up of this substance or toxic injury to tissues following proper parenteral administration.
4. Nausea, flushing, a sensation of heat and perhaps mild muscular pains may accompany the too rapid administration of amino acids intravenously. These symptoms are transient and are not serious.
5. Severe toxic reactions may occur if amino acid mixtures are given parenterally to individuals with severe hepatic damage, e. g., diffuse toxic hepatitis (acute yellow atrophy)¹⁰.

Amino acid mixtures may be administered intravenously, subcutaneously, per rectum, by mouth, stomach tube, duodenal tube, or enterostomy.** In our eagerness to give substances directly into the blood stream, we often fail to use a more convenient and more practical portal of administration. It has been shown that amino acids put into the duodenum are rapidly absorbed at this site and in many instances, even in severe diarrheas, administration by duodenal tube may be the method of choice.

It is probable that the next few years will see great developments in the field of amino acid therapy and that amino acids will be widely used and will provide great advantages in the treatment of many diseases. Much valuable information will be gained from the extensive studies now in progress in which

parenteral amino acid therapy is being used to treat war prisoners in the last stages of starvation. It has already been demonstrated that such therapy is often effective when oral administration of protein is not.

It must be emphasized that amino acid mixtures should be regarded as a *food* and not a tonic. They should be used in adequate amounts, which means large amounts, if they are to be used at all. If it becomes necessary to give amino acids parenterally to a person unable to eat food, many additional calories, in the form of glucose, must also be supplied in order that the administered amino acids be used for protein synthesis and not burned for energy. For this reason the solution of choice for intravenous injection is 5 per cent amino acids in a solution of 5 per cent glucose.

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*In certain allergic states amino acids have proved to be a valuable substitute for dietary protein.

**Intrasternal infusions may be a valuable method of administration and one by which the sclerosis of veins (because of the hypertonicity of the solution) may be avoided.

Franklin On Fresh Air

It has been said that Franklin opened the windows of America. The following indicates that he tried to open the windows of England.

"He insisted always on ventilation and fresh air, and heretically kept his windows open at night. 'What caution against air, what stopping of crevices, what wrapping up in warm clothes, what shutting of doors and windows, even in the midst of summer!' he wrote to Thomas Percival on 25 September 1773. 'Many London families go out once a day to take the air; three or four persons in a coach, one perhaps sick; these go three or four miles, or as many turns in Hyde Park, with the glasses both up close, all breathing over and over again the same air they brought out of two with them in the coach, with the least change possible, and rendered worse and worse every minute. And this they call taking the air.' The house in Craven Street might be sometimes crowded but it was always ventilated." — *Benjamin Franklin by Carl Van Doren*, page 406. *The Viking Press. New York. 1938.*

CLINICAL PATHOLOGIC CONFERENCE

University of Oklahoma School of Medicine

Presented by the Department of Pathology and Medicine

TOM AVEY, M.D.—HOWARD C. HOPPS, M.D.

DOCTOR HOPPS: The clinical diagnosis of our case for today is rather obvious and I assume that most of you have already made the diagnosis from data previously presented. Its interest lies chiefly in the fact that it typifies a rather unusual form of a fairly common disease, one which still presents a challenge insofar as understanding its pathogenesis and effecting any specific therapy is concerned. Dr. Avey will consider the clinical aspects of this case.

PROTOCOL

Patient: J. L., white male, age 15; admitted May 25, 1945; died June 14, 1945.

Chief Complaint: Headache, generalized edema, and convulsions.

Present Illness: Twelve weeks before admission the patient had an acute sore throat. His physician treated him with sulfonamides and he improved. A week later he noticed swelling of face, hands and feet, and his urine was red. His physician told him he had "kidney poisoning" and that his urine contained red blood cells and albumin. He put the patient to bed and treated him. In spite of treatment the edema became generalized and in about two weeks the patient began to notice headaches, which became progressively more severe. On May 5, 1945 the patient had five convulsions which lasted about five minutes each. There was no recurrence until May 24, 1945 when he experienced nine convulsions, more severe than formerly. He was then brought to this hospital.

Past and Family History: The patient had had mumps, measles and pertussis. An appendectomy had been done in November, 1944. Family history was non-contributory.

Physical Examination: On examination, a well developed, rather poorly nourished boy was seen, pale and edematous. He was mentally clear. The lids were edematous. Moderate papilledema was noted bilaterally. The lips were swollen and the breath had a urinous odor. The lungs were clear, the heart was within normal limits; no murmurs were heard. The blood pressure was 188/130. The abdomen was flat with bulging in the flanks.

No fluid wave was noted. There was swelling of the external genitalia and extremities, and all skin surfaces were edematous.

Laboratory Data: On May 25, 1945 the urine was cloudy, acid and red-yellow; the specific gravity was 1020, there was 3 plus proteinuria, no glucose. Innumerable red blood cells, white blood cells and many hyaline casts and granular casts were present. The hemoglobin was 9 Gm. and there were 3,140,000 red blood cells and 13,800 white blood cells with 74 per cent neutrophils and 26 per cent lymphocytes. The blood N.P.N. was 60 mg. 100 cc. On May 29, 1945 the urine contained three plus proteinuria; microscopic findings were as before. On June 6, 1945 there was two plus proteinuria, rare red blood cells, 60 white blood cells per h.p.f., and many hyaline and granular casts. On this date the N.P.N. was 57 mg. 100 cc. and plasma proteins 4.7 gms. per cent.

Clinical Course: The patient did not respond well to treatment,—low salt, acid ash diet; magnesium sulfate by mouth and by retention enema and digitalis. The last week of life the patient was placed on a high protein diet and he received one transfusion of plasma. His course was essentially afebrile. Headaches and convulsions continued. By June 9, 1945 the patient was cyanotic, the breathing difficult and the pulse irregular. He was nauseated. Oxygen improved the respiration, but in spite of all measures he expired on June 14, 1945, (total duration of illness, four months and 20 days).

DOCTOR AVEY: Proteinuria with hematuria, generalized edema, the very marked hypertension for a boy of 15 years, viz., 188/130, a history of headaches and convulsive seizures, etc. combine to give a textbook picture of glomerulonephritis. The onset of this condition one week following a sore throat presumably caused by beta hemolytic streptococci is also typical. It is of special interest that this initial streptococcal pharyngitis was treated early and adequately by one of the sulfonamides. It seems reasonable to believe that specific bacteriostatic therapy of this sort should appreciably reduce the

incidence of such complications as glomerulonephritis. It is yet too early however for statistical evaluation of such effects. Regardless of this, however, what appears to have been adequate sulfonamide therapy did not prevent a fulminating type of glomerulonephritis in this boy. As a matter of fact, throughout the course of this boy's disease he received what, by our present standards, must be considered good treatment. He was given adequate bed rest early; dietary measures were employed to reduce the edema; mercurial diuretics or other agents of this type that would have further irritated an already badly damaged kidney were not used, etc. In spite of this and the initial treatment to control the streptococcal infection, the course of this disease was relentlessly progressive, terminating in death four and one-half months after the first renal symptoms.

One might question whether or not sulfonamide therapy was partially responsible for the renal injury. I think this a very remote possibility since the onset of renal insufficiency occurred five days after sulfonamide therapy had been discontinued and was accompanied in its initial stages by edema of a type which is characteristic of glomerulonephritis — an edema of peculiar distribution affected primarily (in early acute glomerulonephritis) but some toxic effect on capillary endothelium. Even in fatal cases of obstructive nephropathy produced by sulfonamides, edema is obviously secondary to uremia and is not manifested in the initial stages of the disease as it was in this case.

This disease is not *lipoid nephrosis* because, (1) there was marked hematuria. (2) there was retention in the blood of nitrogenous elements. (3) there was marked elevation of blood pressure; none of these occur in *lipoid nephrosis*. This condition was not one of *pyelonephritis* because of the absence of any indications of bacterial infection (save for the initial sore throat from which he had recovered *before* the onset of nephritis) during the course of the disease and again because of the predominant edema and hypertension which would be most unusual in *pyelonephritis* of but a few months duration. That rare condition of *acute interstitial nephritis* which occasionally follows acute infectious processes is practically never fatal and heals spontaneously in a week or two leaving no, or little residual effect.

We could discuss the laboratory findings at great length in this case; this is probably not warranted though since such data, directly applicable, are carefully analyzed in many texts, e. g., Fishberg's Hypertension and Nephritis. It is quite significant that this patient, even though his urinary output was limited to around 500 cc. much of the time,

was able to concentrate his urine only to 1.009-1.012. This inability to concentrate urine — a normal individual should excrete urine of 1.030 specific gravity upon restriction of fluids for 12-14 hours — constitutes a most simple and at the same time a very important test of renal function. Regarding uremia it should be emphasized that clinically, this represents a most variable symptom complex and one which does not necessarily vary directly with the degree of nitrogen retention in the blood. One may see uremic convulsions in a case where the blood N.P.N. is but 80 mg. per cent. The retention of certain phenols and other toxic agents is more directly related to the symptoms of uremia than is that of urea, creatinine or uric acid retention.

The course that this patient followed is typical of subacute glomerulonephritis regardless of treatment. Let us review, however, what treatment was given and its rationale. One question that is always raised concerns the amount of dietary protein allowed. Some men, notably Addis, during the first week or two of acute glomerulonephritis restrict proteins to an absolute minimum in order to provide as much rest for the kidney as possible during the initial stage of the disease. Such restriction is limited to the very early stages however. More and more clinicians are coming to realize that in *sub-acute* and *chronic* glomerulonephritis there is a protein deficiency which deserves remedial treatment rather than aggravation by protein restriction. You will notice that this patient had a blood plasma protein of 4.7 gm. per cent which is well below the edema level. His initial diet, a low salt acid ash diet, was rather low in protein. Later this was changed to a high protein diet. Additional transfusions with plasma might have been indicated to further combat this hypoproteinuria. Digitalization was begun toward the end in order, primarily, to increase renal blood flow and provide every opportunity of that sort for the best renal function possible under the circumstances.

DISCUSSION

CLINICAL

QUESTION: In regard to specific gravity of the urine, to what extent does proteinuria affect this?

DOCTOR AVEY: In most instances it can be disregarded since even a "four plus" proteinuria may raise the specific gravity only 0.002 or 0.003.

QUESTION: Were there cardiac abnormalities disclosed by the electrocardiograph?

DOCTOR AVEY: There was some left axis deviation and clinically, evidence of beginning decompensation. That was our indication for digitalization.

QUESTION: Would spinal puncture and withdrawal of fluid have helped?

DOCTOR AVEY: In uremia, edema of the brain proper is the major factor in the compression. I do not believe that a spinal tap was indicated.

ANATOMICAL DIAGNOSIS

DOCTOR HOPPS: Before I present the pathologic findings I should like to present a classification of nephritis.

ACUTE GLOMERULONEPHRITIS may terminate in:

- (a) *Complete recovery* (the majority).
- (b) *Death* during the acute stage (weeks).
- (c) *Subacute Glomerulonephritis* — a continuous progressive disease terminating fatally (months).
- (d) *Temporary remission* with subsequent exasperations and remissions — ultimately terminating in uremia — *Chronic Glomerulonephritis* (years).

This classification is a modification of Van Slykes and seems to me to present well the various possibilities in a simple manner. On the basis of this classification it is obvious that this boy had subacute glomerulonephritis which, for practical purposes, is an invariably fatal form of the disease. I should like to emphasize that in probably 90 per cent of cases of acute glomerulonephritis, especially in children, the lesion heals completely, in a few weeks and does not give further trouble. Next most common is a temporary remission to be followed by repeated exacerbations with death ultimately years, perhaps even 20 or 30 years, later. Death from subacute glomerulonephritis probably occurs in but one per cent or so.

The most striking characteristic of this patients postmortem was the very marked degree of anasarca. His body was at least 50 per cent edema fluid. Four months before he had weighed less than 100 pounds; at necropsy, in spite of progressive malnutrition, he weighed 185 pounds. Externally this was evident in the pallor of the skin and marked pitting upon pressure anywhere over the body. Loose areolar tissue, as in the external genitalia, is a favorite place for edema fluid to collect and the scrotum in this 15 year old boy was distended to a diameter of 14 cm. In addition there were broad striae over the arms, abdomen, thighs and even the lower legs from the over stretching of the skin and separation of elastic fibers. Internally, edema was everywhere evident also, but particularly in the body spaces. There were 6 to 8 liters of clear straw-colored fluid in the abdominal cavity, 4 liters in the two pleural cavities and 130 cc. (in contrast to the nor-

mal 20-30 cc.) in the pericardial cavity. This accumulation of fluid in itself added considerably to the difficulties of this patient. The ascitic fluid elevated the diaphragm causing pressure on the lungs from below and the pleural fluid added still more compression so that there was considerable pulmonary atelectasis, along with hyperemia and edema. The heart was approximately 10 per cent enlarged for the age. This with the moderate increase in thickness of the left ventricle represents an effect of hypertension of a few months duration. The myocardium was flabby and the right auricle and ventricle were markedly dilated. From this one would say that heart failure was an important factor in terminating life. The kidneys presented a typical appearance: one weighed 195 gm. and the other 210 gm. They appeared swollen and were much paler than normal save for ill-defined, irregular, splotchy areas of purple. The cortical surface was finely granular. The cut surfaces bulged markedly and revealed a thickened, pale cortex which presented many tiny yellow flecks less than 1 mm. in diameter.

The parathyroid glands were examined and were moderately enlarged. Such a change is usually found in cases of chronic renal insufficiency where the kidneys finally become unable to secrete phosphates and these begin to accumulate in the blood stream. In order to maintain proper Ca:P balance, there is hyperplasia of the parathyroid glands and hypercalcemia. If this effect is sufficiently marked and is prolonged, considerable changes can result in the skeletal system as a result of calcium depletion, a fibrous replacement of bone. This latter was not exhibited in this case; it was hardly expected due to the relatively short period of renal insufficiency. Microscopically, the kidneys are of the greatest interest and reveal a rather typical glomerulonephritis with changes perfectly compatible with the known duration in this case of three and one-half months. In addition to the more spectacular crescent formation one should observe the marked proliferative changes of both epithelium and endothelium which have occurred within the confines of the visceral layer of Bowman's membrane. The explanation of renal failure and hypertension (based on renal ischemia) becomes readily apparent when one appreciates that the majority of glomerular capillaries have become swollen shut from this cellular proliferation and edema within their walls.

There was one additional finding of special interest and that is a congenital anomaly of the heart, a bicuspid aortic valve. Insofar as this patient was concerned it was purely incidental. I call attention to it because it is, next to rheumatic endocarditis, probably

the most important lesion which predisposes to subacute bacterial endocarditis.

DISCUSSION

QUESTION: Would the administration of amino acids have been of value in this case?

DOCTOR HELLBAUM: Certainly a patient such as this should have had a high protein diet. Many of our ideas regarding the deleterious effects of high protein diet are based on faulty experimental work done many years ago. Plasma is often given in such cases and is of great value as a temporary measure in restoring a proper osmotic pressure to the blood and restoring blood volume; it is a poor food however. In this case I believe that amino acids would have been an ideal way to restore the protein level with least extra work on the part of the patient. It could well have been given by mouth without necessitating an increased intake of fluids.

QUESTION: Do you think that sulfonamide therapy should be used routinely in infections such as this to minimize the incidence of glomerulonephritis?

DOCTOR AVEY: I do not. There are a considerable number of patients sensitized to these drugs who would get bad reactions.

DOCTOR HOPPS: I completely agree with Dr. Avey. Remember that only a small number of persons get glomerulonephritis following acute streptococcic infections and that the majority of these suffer no serious ill effects. I'm perfectly sure that even though sulfonamides were completely effective in preventing glomerulonephritis (and they weren't in this case) one would encounter more trouble as a result of the therapy than would have resulted from the glomerulonephritis.

QUESTION: What determines the body's ability or inability to recover from glomerulonephritis?

DOCTOR HOPPS: That's one of the questions we're still trying to answer. This factor does not depend upon the number of glomeruli injured because one of the outstanding characteristics of this disease is that every glomerulus of both kidneys is injured to some extent. Apparently some are injured but slightly and may recover completely. Others, injured more severely, may recover in part or will perhaps be completely destroyed. It is the extent of the injury plus its duration that determines the outcome.

QUESTION: Was it the toxins of the hemolytic streptococci which produced this condition?

DOCTOR HOPPS: No, not directly. From the many studies on this disease it is quite

apparent that first, it is not a primary infection, i. e., there are not bacteria present in the kidney itself; second there is no known endo-or exo-toxin nor any other chemical inflammant which in itself can produce this specific disease although of course they may produce an inflammation of the kidney. On the other hand it is quite obvious that glomerulonephritis is related to acute infectious processes, especially infections with beta hemolytic streptococci. The bulk of evidence, which I do not have the time to present, suggests that glomerulonephritis represents an allergic inflammatory disease, a disease which insofar as its fundamental mechanisms are concerned is somewhat similar to rheumatic fever, rheumatoid arthritis and certain types of primary arteritis, e. g., periarteritis nodosa. This hypothesis explains the fact that only a few persons get the disease following streptococcic infection, that the occurrence of glomerulonephritis and its severity bears no direct relationship to the severity of the initial infection and, finally, it explains why glomerulonephritis usually developed after the infectious process has passed its peak or completely subsided as in this case.

Fothergill and Franklin, the 18th Century's Best In Two Great Countries Get Together

Impatiently waiting, Franklin had a serious illness that lasted eight weeks. About the first of September, he told his wife, he had a "violent cold and something of a fever" for a day or two, and then thought he had recovered. "However, it was not long before I had another severe cold which continued longer than the first, attended by great pain in my head, the top of which was very hot and, when the pain went off (very sore and tender. These fits of pain continued sometimes longer than at others; seldom less than twelve hours, and once thirty-six hours. I was now and then a little delirious; they cupped me on the back of the head, which seemed to ease me for the present; I took a great deal of bark (cinchona) both in substance and infusion; and, too soon thinking myself well, I ventured out twice to do a little business and forward the service I am engaged in, and both time got fresh cold and fell down again. My good doctor (Fothergill) grew very angry with me, for acting contrary to his cautions and directions, and obliged me to promise more observance for the future. He attended me very carefully and affectionately; and the good lady of the house nursed me kindly. Billy was also of great service to me, in going from place to place where I could not go myself, and Peter was very diligent and attentive. I took so much bark in various ways that I began to abhor it; I durst not take a vomit for fear of my head; but at last I was seized one morning with a vomiting and purging, the latter of which continued the greater part of the day, and I believe was a kind of crisis to the distemper, carrying it clear off; for ever since I feel quite light-some, and am every day gathering strength; so I hope my seasoning is over and that I shall enjoy better health during the rest of my stay in England."—*Benjamin Franklin by Carl Van Doren*, pp. 274-275. The Viking Press. New York. 1938.

SPECIAL ARTICLE

THE RETURNING VETERAN*

HUGH M. GALBRAITH, M.D.

OKLAHOMA CITY, OKLAHOMA

Early in this war there was much discussion, and even indignation, over the number of people who were rejected for military service because of nervousness. These rejections were based upon experiences of the first World War, when it was found that there were many people who could not take it when faced with the strains incident to war. Between the two wars there was rapid progress in knowledge of the causes of nervousness, so this knowledge was applied rather ruthlessly by many psychiatrists in the hope that the appalling rate of mental diseases after the first war might be reduced. In spite of this, early in the war many breakdowns occurred among soldiers. This led to wild stories about the possible conduct of returning soldiers. According to these alarmists, almost every soldier was supposed to be handled with kid gloves after his return for fear of injuring his delicate feelings and causing him to do something bad, or of driving him to the insane asylum.

Fortunately our more recent experience has given us cause to be much more optimistic than that. Possibly because psychiatrists were strict in ruling out nervous people in the induction examination, returning soldiers are doing all right. By far the greater majority will be able to make the adjustment necessary to fit into civilian life without too much trouble. Many of the younger ones will be more mature, more self reliant, more able to take care of their own problems than they would otherwise have been if they had not joined the army. Indeed, many of these, whose parents ruled them, and who, because of aches and pains or other evidences of instability, had difficulty in holding jobs will now face their families with some degree of defiance until the parents learn to accord them the respect to which they have become accustomed in the army. Almost all of them will be stronger physically and in better health than they were when they were inducted, for the medical care they have received has been the best in the history of the world.

However, although most returning soldiers are not headed for serious emotional diffi-

culties, including the insane asylum, certain relatively minor changes and disturbances in adjustment must be expected. Ordinary civilian life demands cooperation for the good of the community, including keeping the peace. We are taught more or less to love each other and preserve property. Military life changes this attitude by encouraging the development of hate for the enemy, teaching the soldier to kill and to destroy the enemy property, in order to preserve the things we hold dear, including the soldier's life and those of his comrades — and to win the war. This expression of hate over a period of time tends to loosen moral standards in general so that in war time soldiers do things that would be disapproved of in civilian life. Being far from one's loved ones tends to accentuate these problems because love or approval by loved ones is the main thing that makes it possible for us to maintain high standards in moral conduct. In many instances the thoughts of loved ones at home has been sufficient to maintain standards that were kept at home for the most part. But the deprivation and terrors of war time are so great that no one can say how he is going to behave until he is actually faced with them. So in judging your loved ones as they return it is better to forget the past few years they may have been gone and accept them as they are now and go on from there.

Furthermore it is easier to maintain high standards of conduct under peace time conditions than it is to scramble back to those standards after one has deviated from them. Usually this will be accomplished in time. It is most easily done under the influence of a forbearing, understanding and sympathetic environment. The lower moral standards developed in response to an atmosphere of hate. The higher moral standards will be regained most easily in an atmosphere of love. So one can only advise you to exercise patience and forbearance, to avoid nagging and disapproval, if your returning soldier does not behave as you think he should. If you do this you can rest assured that he will respond satisfactorily in most instances.

Restlessness is a common symptom in the

returning soldier. He has become accustomed to many things which are not characteristic of civilian life. He has been in close contact with men in his unit with whom he has faced dangers and with whom he has formed a companionship which is difficult to duplicate where there is not such extraordinary stress. He may miss his buddies for a time and find it difficult to resume his old attachments which made life pleasant for him before he went to the army. His loved ones at home will not be the idealized objects he has dreamed about when he was in foreign lands. After all they are but human and he is likely to have forgotten their imperfections and to have emphasized their good points in his dreams. When he is faced with the reality of objectionable qualities he may become impatient and dissatisfied and express his restlessness by pacing the floor or by going from place to place in a vain attempt to relieve himself of this discontent. In some instances the restlessness may be associated with trembling spells which are other manifestations of his dissatisfaction. Sometimes he will find it difficult to stick to one job, even though he has the best of working conditions, and he may move from one position to another. He may tire quickly and have a great need for rest for which any physical examination will find no physical cause. He may find it difficult to concentrate on work which will require careful attention to details or which requires tact in dealing with people. He may be sensitive to criticism from his boss even though the boss manifests the most kindly consideration. He may crave excitement and take almost any means to satisfy his craving. In most instances, however, this restlessness will be of short duration. As he becomes better acquainted with his loved ones and learns again to appreciate the satisfactions he formerly obtained from them, he will become more calm and better able to cope with the demands of civilian life.

Associated with the restlessness there may be irritability. The approval a man got for doing a good job in the army may seem to him to be lacking when he first approaches civilian life, so that his craving for approval may manifest itself by crankiness. Ordinarily he will be able to control this but in many instances there may be temper outbursts which were quite uncharacteristic of him during his previous civilian life. Occasionally outbursts may become violent but they usually are of short duration and the individual will realize that he has done wrong and will be penitent. This may be followed by fits of depression or moodiness or the development of aches and pains which are very real to the individual but for which no physical basis will be found. Here again a little pa-

tience and even indulgence on the part of loved ones will bring about a radical change within a few weeks or months.

I shall now cite a fairly typical example of problems as I have seen them. A very charming young woman came to me with the story that her husband had just returned after two and one-half years overseas. There was a three year old child to whom both had been devoted before her husband left. Before his departure she had always found him a model husband, but since his return he had been extremely restless, had been impatient with the child and had repeatedly beseeched her to get someone else to take care of the child while she accompanied him to nightclubs or parties at which he overindulged in drinking. He accused her of nagging at him and frequently became petulant when the needs of the baby interfered with her having meals on time or in having the house clean or arranged to suit him. He made unfair comparisons between her and other women and frequently made references to the necessity for a divorce because he said he couldn't take married life. He complained about her parents, who did everything they could to be kind and in general he seemed to resent anyone who had any part of her affections. He had similar difficulties at his place of employment, but fortunately had a tolerant boss and he seemed to do better at his work than he did at home. I advised her to be patient and to manifest in every way she could her love for him and told her that it might even be necessary to let her parents take care of the baby for a time until he became more stable. At last report he was doing much better and there seemed to be every reason to hope that there would be a favorable outcome to this situation.

In general it may be said that the more stable a man was before the war the more easily he will manage his readjustment to civilian life. Of course there will be numerous instances of more extreme difficulties which should be taken to your family physician or to some wise and understanding friend who frequently can do more than those who are closer and more emotionally involved in the situation. Others should see a psychiatrist, but unfortunately one is not always available. In Oklahoma City we plan soon to establish a psychiatric clinic in association with the Variety Club Health Center which should perform a valuable service.

Finally, I should like to say a word about the injured veteran. Depending upon the degree of his handicap he may find his adjustment more difficult. Here again the need for approval is the important thing. If he has the right stuff in him he will want to overcome his handicap and perform a useful

function in the community. He will not want his handicap to be referred to because such reference will have a tendency to make him feel helpless and dependent. For the most part he will have the same lovable qualities that he had before he was injured and those can be brought out by kindly encouragement and approval for the things that he accomplishes. If he can be made to feel that he is a useful member of the community because of his good qualities largely by those who are close to him, he will carry on within his limitations successfully and happily. If one can keep in mind the human being and ignore what is missing or injured and increase his self respect by gently pushing him away from a sense of inferiority and dependency to a life of usefulness, one can do much to help him re-establish his self esteem and to forget his handicaps.

The situation, then, with the returning veteran, no matter how handicapped he may be by his injuries, is far from hopeless if the proper conditions are established by us who have been fortunate enough to avoid the stresses and strains of war. We owe a debt to him that mere financial assistance can never repay. Only personal endeavors on our part can repair the damage he has sustained.

*Broadcast over WNAD, Norman, Oklahoma, October 31, 1945.

Careers In Medicine

A preliminary training in pharmacy, such as I had, is not infrequently followed by a career in medicine. Dr. John Fothergill, who became a distinguished London physician in the eighteenth century, was brought up a Quaker, became indentured as an apothecary's apprentice, served six years of a seven year term, and then entered the University of Edinburgh expecting to continue in pharmacy, but under the influence of a great anatomist, Monro *primus*, he altered his aim and studied medicine instead.

In later years, when I read Michael Foster's *Claude Bernard*, I was interested to find that he, too, had in his teens worked for two years in a drugstore, had assisted his master in the manufacture of a "cure-all," a syrup "compounded of all the spoiled drugs and remnants of the shop," and later on entered the medical school, paying the necessary fees chiefly with the scant money that he earned by giving lessons. He, as everyone knows, became one of the world's greatest experimental physiologists. My start was similar to his, but here, I am afraid, the similarity ends.—*Time and the Physician. The Autobiography of Lewellys F. Barker*, pp. 27-28. G. P. Putnam's Sons. New York. 1942.

Science and Progress

It is discouraging indeed and proves that we have not yet passed the early stages of civilization. Science has progressed. We worship it but we have not yet learned to organize our lives as individuals and social groups on scientific principles. We play with science and have created an infinity of most enjoyable gadgets. But when it comes to the basic functions of social life, production, distribution and consumption, we forget science and act irrationally following traditional lines. And we still believe that we can solve problems by killing each other.—*Progress in Medicine. Iago Galdston, M.D., with a foreword by Henry E. Siegert, M.D., vii. Alfred A. Knopf. New York. 1940.*

VON WEDEL CLINIC



PLASTIC and GENERAL SURGERY
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THE PRESIDENT'S PAGE

I am anxious to say to the members of the Oklahoma State Medical Association that the combined Committee Meeting held on October 7 at the Skirvin Hotel in Oklahoma City was indeed an inspiration to all and especially to the officers of the Association.

The interest and desire to achieve a program that will meet the existing demands was undoubtedly the central thought of every member present. All were impressed with the fact that the most minute detail was cared for. This leads us to the conclusion, and a fact which is realized by all, that it is the extra deeds of service rendered to our fellowman that makes the greatest impression, not only to the person to whom the service is rendered but also to the observer . . . the greatest reward being given to the donor. From the smallest child to the man of highest rank and responsibility the extra services that are not in line of duty are the most appreciated. In every organization, business, profession, community, state or national affairs the reward for an unselfish, unrequired deed of service is the one that reaps the greatest in results.

Through this line of thinking it is apparent that our profession and the members of our organization have a responsibility to the masses and can achieve results that cannot be attained through any other effort. I am sure that this will be verified by all who do not stop when they have done the routine service that they are called upon to render.

The above facts were demonstrated in the services to our Association rendered by our visiting guest, Dr. Morris Fishbein, the Governor of our great State, and the legislators who have and will continue to render every service possible to make for better health through better sanitation and a more thorough distribution of our public health program, thereby making a happier commonwealth in which to live.

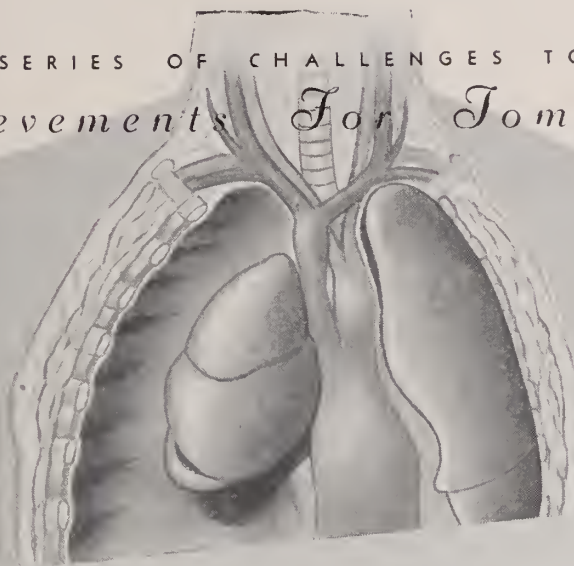


President.

★

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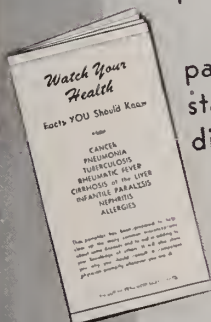


TUBERCULOSIS, an ancient enemy of mankind, stood sixth in causes of death in 1942.* Continuous research, improved standards of living, and the application of new methods of treatment have reduced tuberculosis in the ranks of killers from first place at the turn of the century.

Until an effective vaccine or serum is discovered people must be educated to recognize the symptoms of tuberculosis and to consult a physician before the disease has made much progress.

To aid in such educational work we have prepared a pamphlet entitled "Watch Your Health". In it are simply-stated facts about this and other serious diseases. Copies for distribution to your patients are available on request.

* U. S. Summary of Vital Statistics, 1942.



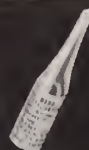
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The JOURNAL of The OKLAHOMA STATE MEDICAL ASSOCIATION

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EDITORIALS

GREAT DOCTORS AND GREAT EVENTS

Seldom do great events transpire without the intimate knowledge of great doctors and not infrequently the course of events follows their thinking and responds to their guidance. Though often such influences are unobtrusive, they are quite important in the course of civilization.

After a lifetime study of Greek history with special attention to the Greek philosophers of the Fifth Century, B. C., Theodor Gomperz¹ came to the conclusion that Greek physicians initiated the age of enlightenment through "the slow emancipation of science from the mythological traditions of the childhood of the world." Gomperz goes on to say, "It is the undying glory of the medical school of Cos that it introduced this innovation in the domain of its art, and thus exercised the most beneficial influence on the whole intellectual life of mankind."

Medicine dedicated to truth and disciplined in the art of straight thinking has a right to be heard. Of great interest to us today is the intimate friendship of our own Dr. Benjamin Franklin and England's greatest contemporary physician, Dr. John Fothergill and their influence upon the affairs of two great countries. In the early part of 1775 we

find that Franklin's negotiations in London had been unsuccessful. He had hoped against hope. He had spent much time with his friend and physician, Fothergill, who had helped to keep him informed. Though Franklin had sent Josiah Quincy on to Boston with secret messages, he remained to guard his country's interests. Quincy, suffering from advanced tuberculosis, died on the voyage. Franklin then decided to sail for America but he was threatened with restraint by the British Government.

"Nothing else interfered, and Franklin made his farewells, which he did not know were his last as a subject of the Empire. He thought he might come back in the fall, though he finally turned the agency for Massachusetts over to Arthur Lee. On the 19th, Franklin spent several hours with Burke, who made his great and unavailing speech on conciliation three days later. Burke moved, almost as Franklin might have done, that Parliament repeal its objectionable acts and leave American taxation to Americans. His last day in London Franklin spent alone with Priestley, from morning till night. Strangers, Priestly wrote, often thought Franklin cold and reserved. But that day he was deeply stirred by the prospect of civil

war, which he thought he had done all he could to prevent. He was reading newspapers from America, telling Priestley what to extract from them for the English papers. Now and then the philosopher could not read for the tears that filled his eyes and ran down his cheeks. If there should be a war, he was sure America would win, but it would take ten years, and he would never live to see the end."²

In support of our theme, we cite the following significant statement and the frank observation of the great English doctor on the worthless parasites of his day.³ "In the evening he received a letter from Fothergill, who asked Franklin to get their friends together in Philadelphia and tell them how the peaceful negotiations had failed. Tell them, as to the British government, that 'Whatever specious pretences are offered, they are all hollow; and that to get a larger field on which to fatten a herd of worthless parasites is all that is regarded.' The Doctor, in the course of his daily visits among the great in the practice of his profession, had full opportunity of being acquainted with their sentiments, the conversation everywhere at this time turning upon the subject of America."

The fact that political intrigue is not new makes it none the less obnoxious to physicians who, because of their professional vantage point, know what is going on and yet because of their training and experience find it difficult to remain silent in the face of corruption. It is time for doctors to follow the example of Fothergill and speak out.

1. Gomperz, Theodor. *Greek Thinkers*. Translated by Lauri Magnus, M. A. John Murray. London. 1901.

2. Van Doren, Carl. Benjamin Franklin, p. 520. The Viking Press. New York. 1938.

3. Van Doren, Carl. Benjamin Franklin, pp 520-521. The Viking Press. New York. 1938.

A SIGNIFICANT MEETING

The meeting of the Oklahoma State Medical Association called by the President on Sunday, October 7, for the purpose of rounding out the work of the various special and standing committees and receiving their reports may prove to be one of the most significant occasions in the history of the Association. This well attended meeting, obviously charged with enthusiasm, may be considered a genuine tribute to our president, Dr. Tisdal, and a summation and correlation of the four-point Educational Program for which he has worked day and night during his administration.

If the program as planned can be fully executed, the beneficial results to the people of Oklahoma will be far reaching. It is of such distinct merit, already other states are requesting information and looking to Oklahoma for leadership. Our successful Legislative Program has helped to arouse the interest of the other states.

Dr. Morris Fishbein attended all the general meetings and met with the Publicity and the Public Policy Committees. Repeatedly he expressed approval and manifested gratification and surprise at the scope of Dr. Tisdal's program.

The meeting closed with a dinner session in the Venetian Room of the Skirvin Hotel. At 9:00 P.M., following the dinner, there was a radio broadcast in which Dr. Tisdal, Dr. Fishbein and Governor Kerr participated. This final session, attended by members of the State Legislature, broadcast to the people of the State, and photogarphed for the movie News Reel, was of great educational value.

The members of the Association throughout the State should be proud of the work done by their officers, the council and the various standing committees, and they should be ashamed to stand idly by while the harvest is white. At any rate, all those listed on the Speaker's Bureau should stand ready to deliver the goods when the call comes. It is time to wake up and surprise the experts. . . . Time to follow the leader.

LOFFLER'S SYNDROME

Though much space in medical literature has been devoted to this condition during the past few years, often it passes without recognition. The syndrome consists of transitory lung infiltrations with eosinophilia. In 1932, Loffler first recorded an accurate description of the condition and reported a number of cases. Clinical experience in this country and abroad indicates that the condition is much more common in Europe than in this country.

The syndrome should be kept in mind because it may be mistaken for pulmonary tuberculosis, primary atypical pneumonia or other conditions causing infiltration of lungs. Under the present trend towards mass Roentgenographic study of the lungs, the condition takes on an added significance especially as it so definitely simulates pulmonary tuberculosis. The pulmonary infiltrations are of such a character that they will be considered due to tuberculosis unless proven otherwise. Every patient exhibiting such infiltrations deserves the proof. An erroneous diagnosis of tuberculosis and commitment to a sanatorium in the case of Loffler's syndrome amounts to a serious medical error.

The lesions may occur in one or both lungs with wide or limited distribution. The shadows may be fugitive in character, appearing and disappearing suddenly only to reappear in other areas. As a rule, the Roentgen manifestations disappear within a fortnight. This was stressed by Loffler but clinical experience indicates that the infiltrations may per-

sist or disappear and reappear over a period of months.

Symptoms may be absent or mild but occasionally the patient manifests moderately high fever, dyspnea and substernal oppression. The absence or paucity of physical signs in the presence of Roentgen evidence of moderate or marked infiltration is amazing.

The differential diagnosis cannot be made from clinical manifestations and Roentgenography alone. In all doubtful cases the percentage of eosinophilis should be determined. The final decision may rest upon the results of repeated clinical Roentgenographic and laboratory studies. Let us remember that Löffler's syndrome is a definite clinical entity, benign in character, its course usually lasting only twelve to fourteen days and that it should not be mistaken for pulmonary tuberculosis.

DIAGNOSIS

EVOLUTION OF MECHANICAL AIDS — DEVOLUTION OF THE FIVE SENSES

With the coming of the roentgen ray, the cardiograph, the sphygmomanometer, the cystoscope, the bronchoscope, the thoracoscope and ever-increasing laboratory procedures, the five senses are being neglected. Before the advent of the above diagnostic aids, often the natural avenues of comprehension, the special senses, were developed to a point approaching perfection. What Oliver Wendell Holmes referred to as "intuitive segasity" was largely due to unusual cultivation of the five senses. In truth, intuition is vision sharpened by the acquisition of additional knowledge through accessory senses. The modern tendency toward carelessness in clinical medicine, with serious neglect of bedside study, is the outgrowth of a complex situation comprising many contributing factors, some of which may be enumerated as follows: faulty education; early specialization; increased hospital and laboratory facilities; diagnostic clinics and group practice, with the multiplicity of mechanical aids to diagnosis. To these may be added the natural inclination on the part of many to take the line of least resistance.

What the patient needs is a physician with a practical knowledge of anatomy and physiology, willing to sit at the bedside and bring to bear a sympathetic, intelligent application of this knowledge to the patient's individual needs; a physician who realizes that the human organism is still intact, constituting a composite whole, possessing a human personality and have the right to demand a reasonable amount of individual attention.

Diagnosis becomes an interesting game only when it is closely identified with flesh

and blood and illumined by the intimate flashes between minds mutually interested in the pursuit of truth. It has been said that "while you are diagnosing the patient, the patient is diagnosing you." Obviously the game becomes more fascinating as the patient and the doctor each attempt to fathom the others' mental reservations without revealing his own. The diagnosis as expressed by roentgen ray or cardiogram without a knowledge of symptoms and signs is as lifeless and uninteresting as dry bones compared to living anatomy. The doctor who knows the normal body and the topography of all the organs enjoys the thrill that accompanies the power to detect slight deviations from the normal and the confirmation that may come through mechanical and other laboratory aids when available. The patient who is lucky enough to have such a doctor is most fortunate and usually smart enough to know it.

The doctor may derive great satisfaction thinking he is a good doctor but he will never achieve great success as a clinician until the patient thinks he is a good doctor. The patient will never reach this conclusion until he experiences the psychological lift of a genial bedside manner, the reassuring touch of a physical examination and the unhurried sympathetic explanation of his case with a frank prognosis.

The five senses sharpened on the whetstone of practice may become incredibly keen and prove to be a great boon to both patient and doctor.

PROGRESSION VS. RETROGRESSION

Henry Christian once said, "Physicians can be divided into two great groups; those that are learning and those that are forgetting; those that each year know more, and those that each year know less. There seems no third group, those that are stationary."

This is not new thinking. Throughout the ages, philosophers have recognized these two groups and people have perpetuated them through sheer indifference and a high percentage of mental inertia.

Perhaps Henri Frederic Amiel made the most poignant statement on this issue approximately one hundred years ago when he wrote in his Journal: "He who is silent is forgotten; he who abstains is taken at his word; he who does not advance, falls back; he who stops is overwhelmed, distanced, crushed; he who ceases to grow greater becomes smaller; he who leaves off, gives up; the stationary condition is the beginning of the end, it is the terrible symptom that precedes death."

These words from a great man should command our serious consideration. They do not come upon us with full force until we

have read them over and over. Having done this, we should take stock and chart our course. It is never too late to mend. On the road to medical progress, we find good medical literature, time for reading and study; local, state and national medical meetings; contact with colleagues and leaders in medical thought; refresher courses, clinics and scientific exhibits. In addition to the above, one of the most effective ways to keep oneself in the progressive group is to make systematic clinical records and to write case reports and scientific articles based upon such records. Such contacts and such experiences are stimulating, much more stimulating than can be realized by those who are in the retrogressive group.

Fortunately, the Oklahoma medical profession is up and coming and it is to be hoped that the growing ranks of those who are learning may ultimately wipe out those who are forgetting.

WHEN AND WHENCE WILL WAR BRING PEACE AND GOOD WILL

For the benefit of those who think Peace has come bearing the Universal brotherhood of man, we call attention to the fact that progress is understood only when our knowledge is sufficient to permit an intelligent comparison of the present with the past.

While we have had a million years of man, we have recorded only a few thousand years of civilization. Since wars have not ceased under the rule of civilization it is reasonable to believe there were millions of wars before there were rumors of wars.

Always there is the contest between wealth and poverty, extending from individual conflicts up through social and economic groups and agencies to the chaotic strife between nations. Always there is the threat of political ambition placing in jeopardy personal liberty.

Those who are confused and bewildered by our present national social, economic and political strife and the existing world chaos may do well to study history and read the literature of different periods in order that they may feel the spirit of the past and hear the small voice of the ages. Those who haven't time to follow the march of Mars through the pages of history should at least read "The Enemy."¹ All those who marched forth to "make the world safe for Democracy" and all who remained behind to sustain them and to cheer them on their way should read this significant four-act play. In this moving tragedy of World War I we find a vital sermon which should be revived. In the Forward, Pierre de Rohan says that, "The Enemy will be condemned by professional sol-

diers whose jobs are at stake; it will be sneered at as pacifist propaganda by politicians whose only hold on the public is its willingness to be spellbound by empty oratory and frenzied flag-waving; it will be frowned upon by mawkish pedagogues whose dogma includes a daily salute to the flag; it will be ridiculed by smart, young critics and jealous fellow playwrights as theatrical hokum. But wherever it is played it will make people think; and when people begin to think, the hatred of nations will dissolve into its own shadow, and armies and navies will go the way of moats and palisades."

Coming down to date on our own social, economic and political unrest, we quote from James Bryan's* "Will Peace be Endurable?"²

"To fancy that we can solve the *basic* problems of the industrial society merely by dispensing "social security" is monstrous charlatany. A functioning society of free men will be created not by relieving men of risks and responsibilities, but by making certain that every man shall have his full share of the social burdens and benefits of his day. To abolish the fear of war, famine, unemployment and poverty in old age is elementary social sanitation — on a par with the abolition of polluted water or contaminated milk.

"But to look upon social insurance as a liberator of human energy would be fatal to a free society. What men chiefly hunger for on this cold little planet is *not to be free of want*, but something important that *they may urgently and hopefully want!*

"The society that deprives most of its members of a sense of responsibility and purpose in their daily lives is no society at all. It is a mass of rootless, rudderless individuals, ripe for the sirens from right or left who will exploit the basest impulses of the mass, either for bloody aggression or for craven security. This is the soil in which fascism and communism sow their whirlwinds."

The collective effort of the masses to bring about moral, social and economic equanimity has failed to keep pace with scientific and mechanistic progress. Unless something can be done to bring up the level we are lost. Of all the professions and agencies in the field of human endeavor it would seem that medicine manifests the most generous and comprehensive approach to the mounting frustrations inseparably linked with the march of time.

*James Bryan is Executive Secretary of the Medical Society of the County of New York, and Managing Editor of New York Medicine. He is the author of several articles which have appeared in medical journals.

1. Channing Pollock. The Enemy. Pierre de Rohan, page 6. Brentano's. New York. 1925.

2. James Bryan. Will Peace Be Endurable. The American Scholar. Vol. 14, No. 4, page 468.

ASSOCIATION ACTIVITIES

DICK GRAHAM ASSUMES FIELD DIRECTORSHIP OF POST-GRADUATE COURSE

With the resignation of Mr. L. W. Kibler as Field Director of the Postgraduate Course conducted by the Postgraduate Committee of the Association, Mr. Dick Graham, Executive Secretary, has assumed the duties and the Course will continue under his direction.

Due to this change in directorship it will be necessary that the County Societies and individual members make a greater effort to minimize the amount of field work necessary. Every physician in the state who has participated in this program in the past knows the value of the program and that it has always been sponsored in part through the financial contributions of the State Health Department and the Commonwealth Fund and it is hoped that in the near future the physicians of the state will realize its worth to the extent that it will become self sustaining.

A.M.A. HOLDS PUBLIC RELATIONS CONFERENCE

The Council of Medical Service and Public Relations of the American Medical Association which was established in 1942, initiated a program of consultation with State Medical Associations concerning public relations and current medical economic programs that is particularly attractive to the Associations inasmuch as it gives them an opportunity to directly participate in this important field of present day medical programs. The Council is to be complimented on this forward and progressive step and it is believed that it will be to the benefit of both the American Medical Association and the State Medical Associations in bringing about a closer cooperation.

The following subjects were covered by the Conference and were topics for the roundtable discussions: Legislation; Extension of the EMIC Program; The Public Relations Job; Placement of Medical Officers; Prepaid Medical Insurance Plans; Rural Health Problems; Activating Fourteen Point Constructive Program for Medical Care; Veterans' Administration. All roundtable discussions were attended by representatives from the Oklahoma State Medical Association and the recommendations that were made to the Board of Trustees through the Council will be published upon their being assembled and communicated to the Association.

Attending from Oklahoma were Dr. F. W. Ewing, Muskogee; Dr. McLain Rogers, Clinton; Dr. James Stevenson, Tulsa and Mr. Dick Graham, Oklahoma City.

Two of the highlights of the program were the discussion of the suggested organization of a nationwide prepaid medical and surgical plan and the discussion by Major General Paul R. Hawley outlining the plans of the Veterans Administration.

The suggested plan of a nationwide prepaid medical and surgical plan was presented by Mr. Don C. Hawkins, Executive Assistant of the St. Paul Fire and Marine Insurance Co. The program presented by Mr. Hawkins outlined a procedure whereby State Medical Associations not having their own prepaid plans could avail themselves of this national organization in order that there could be nationwide coverage. No different commitments were made by the representatives of the State Medical Associations as to the advisability of this plan but a final recommendation was made to the Council on Medical Service and Public Relations that there be a call meeting at the time of the A.M.A. meeting in Chicago December 2 at which time at least every repre-

sentative from each Medical Association would be asked to be present to further discuss this subject.

Major General Paul R. Hawley of the Veterans Administration, in discussing the plans of that organization, stated that medical care would be made available to all veterans. He outlined the attitude of the Veterans Administration in changing its present plans of operation to include a more diversified plan of operation wherein veterans would be allowed to select their own physicians, and have treatment in their home communities without the necessary expense of being transported to veterans' hospitals. Veterans' hospitals will continue to be increased in size and more for the specific purpose of handling veterans needing specialized care or future hospitalization of chronic conditions. General Hawley impressed the meeting with the fact that the Veterans Administration was fully cognizant of many of its shortcomings and that steps were being taken to correct these situations as rapidly as possible.

ANNUAL MEETING OF ASSOCIATION TO BE HELD

The Annual Meeting of the Oklahoma State Medical Association will be held in Oklahoma City at the Skirvin Tower Hotel, May 1, 2 and 3, 1946.

As nearly as possible the meeting will be a revival of the old time meetings with the usual features. Since there is still a difficult situation with regard to rooms, it would be advisable for those physicians who are planning to attend, to make reservations well in advance of the meeting date.

OKLAHOMA COUNTY MEDICAL SOCIETY APPROVES OKLAHOMA PHYSICIANS SERVICE

At a meeting on October 23, the Oklahoma County Medical Society unanimously approved the Oklahoma Physicians Service.

Enrollment will begin in the near future through groups covered by Blue Cross.

SECOND MEETING OF THE BOARD OF TRUSTEES OF THE OKLAHOMA PHYSICIANS SERVICE

The second meeting of the Board of Trustees of the Oklahoma Physicians Service was held on October 22 at the Oklahoma Club in Oklahoma City. The Chairman of the Board, Mr. Glen Leslie of Shawnee, announced that the Plan had been accepted in thirteen County Medical Societies and that there were now 1,250 people covered, 12 surgical procedures have been paid thus far.

Dr. James Stevenson, Tulsa, Treasurer, reported that the Oklahoma Physicians Service was in a position to meet all bills rendered and that the growth of the Plan was more rapid in proportion than that which had been enjoyed by the Blue Cross during its formative years.

ASSOCIATION HONORS GUEST SPEAKER OF BAR ASSOCIATION

On Friday, October 26, the Association entertained with a luncheon at the Skirvin Hotel honoring Dr. Lemoyne Snyder, Medical Legal Director of the Michigan State Police. Dr. Snyder was one of the guest speakers at the banquet the same evening held by the Oklahoma Bar Association.

Dr. Tow Lowry, Dean of the University of Oklahoma School of Medicine acted as toastmaster and Dr. W.

Floyd Keller introduced the guest speaker, Dr. Snyder stated that it isn't only the criminal angle of homicide that we should be interested in, but in many other medical phases. Thorough and complete investigation at the time of an accidental or homicidal death avoids court action years later. He then cited the scientific progress in determining the degree of drunkenness of individuals involved in accidents.

The question was raised as to what qualifications would be necessary for a coroner. Dr. Snyder replied by stating: "There are no qualifications for coroners, in most places they are merely elected officers. Less than 20 per cent of them are doctors and half of them are undertakers. I believe in the Medical Examiner System. It is much better than any coroner system. The person qualified should be a doctor of medicine and must have particular training in the field of legal medicine."

DR. MORRIS FISHBEIN IS GUEST AT COMBINED COMMITTEE MEETING ON OCTOBER 7

On October 7 the Oklahoma State Medical Association held a combined meeting of all Committees for the purpose of outlining a program of activity for each Committee. The attendance was excellent and each Committee was well represented.

Individual meetings were held in the forenoon and at 12:30 luncheon was served in the Empire Room. In addition to members of committees and officers of the Association, there were a number of guests present.

Dr. Fishbein spoke briefly at the luncheon, discussing the medical officers in the armed forces and arrangements that were under way for them when they were released. He then commended the Oklahoma State Medical Association for its efforts and its far reaching program of education. Dr. Fishbein also discussed the pending national medical legislation and the effects on the medical profession.

The all-day session was brought to a close by a banquet at 7:00 P.M. in the Venetian Room at the Skirvin Hotel which was attended by 185 committee members, officers and guests. Honored guests included Dr. Morris Fishbein, Governor Robert S. Kerr and Senators and Representatives of the 20th Oklahoma Legislature. From 9:00 P.M. to 9:30 P.M., Station KOCY, Oklahoma City, carried a broadcast in which Governor Kerr and Dr. Fishbein participated. Moving pictures of the speakers and guests were taken by the Griffith Amusement Company.

Following are committee reports presented at the meeting. Others will appear in the next issue.

REPORT OF COMMITTEE ON PUBLICITY

The Publicity Committee of the Oklahoma State Medical Association met October 7, 1945, at the Skirvin Hotel. Dr. Morris Fishbein was present as a guest but entered actively into the various discussions and gave the committee information as well as offering several

valuable suggestions for furthering good publicity of the medical profession.

The previous work of the committee was reviewed. Plans were then discussed for enlarging and extending the different phases of publicity. As a result of these discussions it was felt that the various phases of publicity should be differentiated and the following recommendations are offered for consideration.

1. SPEAKER'S BUREAU.

It was felt that this endeavor had extremely valuable possibilities and that its scope was wide. The committee thought that there should be a careful selection of speakers and that there should be a close correlation of this phase with educational activities.

2. RADIO BUREAU.

For this means of publicity to be effective, it must have long range planning, close supervision and, above all, the subjects discussed must have appeal to the radio audience, presented by good speakers, at appropriate listening times.

3. PRESS BUREAU.

This is a field of publicity that has been tried but not always with the best results, these failures being largely due to the inaptitude of the medical profession. For this to be successful, there must be careful supervision of the writing of articles, presented at regular times and upon subjects that have reader interest. Secondly, there should be a close liaison between the press and this bureau so that the press would feel free at all times to discuss any medical news with the bureau before publications.

4. VISUAL EDUCATION.

This being a very new phase, there was considerable discussion as to the ways and means of best effecting this. The committee fully realizes that this would reach a great number of people and that it could be used as an educational phase without equal. It, therefore, endorses the idea, but felt that at this time it did not have enough information to make any definite recommendations.

Signed: John F. Burton, M.D., Chairman

O. E. Templin, M.D.
J. William Finch, M.D.
C. E. Northeutt, M.D.
Tom Lowry, M.D.
J. L. Patterson, M.D.
J. V. Athey, M.D.
Clinton Gallaher, M.D.
J. G. Edwards, M.D.
E. M. Woodson, M.D.
John A. Haynie, M.D.

REPORT OF COMMITTEE ON POSTWAR PLANNING

A report of your Committee on Postwar Planning was published in the November, 1943 issue of the Journal, a subsequent report was published in July, 1944, and a subsequent report was made to the Council of the Oklahoma State Medical Association on October 22, 1944.

Since our last report, another questionnaire and let-

WILLIAM E. EASTLAND, M.D.

F. A. C. R.

**RADIUM AND X-RAY THERAPY
DERMATOLOGY**

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ter have been sent to each Oklahoma medical officer in the Armed Forces explaining the provisions of the G. I. Bill, and also to determine the number of doctors who will want to take their postwar training in the State of Oklahoma, what branch of medicine they will want to take it in, and the type and duration of training which they wish. The results of this last questionnaire are as follows:

Total number of doctors who entered the service from Oklahoma is 666. Of these, 31 have returned, and 8 have died in the service.

Two hundred and seven of the last questionnaires have been returned, and of these, 146 expressed a wish for refresher courses, and 140 for residencies. Fifty-five were willing to take residencies in small hospitals and 15 were willing to take internships. Sixty-three wanted their refresher courses in Oklahoma. Fifty-seven wanted their refresher courses in other states. Fifty-eight wanted residencies in Oklahoma. Forty-seven wanted residencies in other states.

The services most in demand were surgery, with 49 requests for refresher courses and 60 for residencies; medicine, with 28 requests for refresher courses, and 20 for residencies; obstetrics and gynecology, with 16 requests for refresher courses, and 19 residencies.

According to available estimate, there are approximately 60,000 doctors in the Armed Forces, and roughly 20,000 to 30,000 of these will remain in the Armed Forces or Veterans Facilities for a prolonged time, and it is the opinion of this committee that the demand for postwar training among those who return will not be as great as the figures might indicate.

In the Journal of the American Medical Association of March 31, 1945, there was published the most recent results of the questionnaire sent out by the A.M.A. This report includes the results of 21,029 questionnaires returned from doctors in the Service. The conclusions of that report were as follows:

1. Future educational desires of medical officers on duty with the Army, Navy, Public Health Service and Veterans Administration were determined by a study of 21,029 returned questionnaires.

2. Nearly 60 per cent of the group, or 12,534, wanted to take long courses of further training in hospital or educational work. Courses of six months or longer were called long courses, shorter courses were called short courses. About one-fifth of the group, or 4,563, indicated that they wanted to take short courses.

3. There were 3,922 medical officers, or 18.7 per cent of the group, who did not want any future training.

4. Requests for short courses included all specialties. The largest number of requests were made for the following specialties in order of frequency: internal medicine, surgery, general review, obstetrics and gynecology, pediatrics, otolaryngology and ophthalmology.

5. The ten most popular special fields of training by means of long courses were in order of frequency of request; surgery, internal medicine, obstetrics and gynecology, general review, psychiatry and neurology, pediatrics, orthopedic surgery, ophthalmology, radiology, and otolaryngology.

6. Nearly two-thirds of the group, or 63 per cent, (13,333) expressed a desire to become certified specialists. There were 3,324 medical officers who had been certified by the American specialty boards, or nearly 16 per cent of the entire group. The remainder of the group either did not care to be certified or did not mention their desires.

7. Most of the medical officers, 8,734 men, or nearly 40 per cent, came from private practice to the military services. Twenty-two per cent came directly from internships (4,640), nearly 10 per cent came directly from residencies (2,191) and the remainder came from other types of practice. About 15 per cent failed to answer the question concerning their previous type of medical practice.

8. A comparison of the results of a pilot questionnaire and the present questionnaire were made. Long courses were requested by about one-fourth more men

in the final questionnaire as in the pilot. The difference was attributed to a change in point of view of medical officers during the interval between the circulation of the questionnaires.

The Postwar Planning Committee is cooperating with the Committee on Post Graduate Medical Training of the Oklahoma State Medical Association, the American Medical Association, the University of Oklahoma School of Medicine, and the County Society in an effort to be of help to the service doctors who will return to civilian life. A survey of the State, including hospital facilities and various information on every community has been made and is available to each returning doctor. A tentative curriculum for eight weeks general refresher course at the University of Oklahoma has been made, and courses will be started when the demands arise. Every effort will be made to supply residencies and fellowships and the kind of training which these men will want and deserve.

Signed: Tom Lowry, M.D., Chairman

Claude S. Chambers, M.D.

J. Hobson Veazey, M.D.

J. B. Hollis, M.D.

Raymond Murdoch, M.D.

REPORT OF COMMITTEE ON CONSERVATION OF VISION AND HEARING

Mr. Chairman:

Our meeting was along the line of hearing aids only. Colonel Geutry and Captain Work from the Borden General Hospital at Chickasha gave us a very illuminating talk on their method of procedure. We feel that they are doing a wonderful piece of constructive work and feel they are to be highly complimented.

After talking to them we feel that probably before much can be done for the public, more information will have to be given to the medicos and probably facilities at the University Medical School will have to be set up and directions for the doctors will have to come from that direction.

Signed: Frank R. Viereg, M.D., Chairman

Marvin D. Henley, M.D.

E. Gordon Ferguson, M.D.

John R. Walker, M.D.

REPORT OF THE CRIPPLED CHILDREN'S COMMITTEE

The Committee on Crippled Children wishes to call to the attention of The Oklahoma State Medical Association:

1. That a recent opinion handed down by the Attorney General of the State of Oklahoma states that it is unconstitutional for any of the public monies to be spent for the care of crippled children in any denominational institution.

As this is merely an opinion, the Committee recommends to the State Medical Association that it advise with the denominational institutions involved and get one of these to agree to make a test case of this point of law.

2. One of the pressing problems in the care of disabled children in the State of Oklahoma is the care, treatment, and training of the cerebral spastic. The committee recommends that initial steps to be taken to the end that some type of institution be established in which training of properly selected cases can be undertaken and proper differentiation can be made between those that cannot be trained and those that are in need of surgical intervention in addition to their training; that these last may be sent to the Crippled Children's Hospital for such recommended procedures before continuing their training.

3. It has come to the attention that there is on deposit in the seventy-seven counties of the State of Oklahoma probably in the neighborhood of \$200,000.00, derived from the March of Dimes Campaign, for the purpose of the care of infantile paralysis cases.

The Committee recommends that a central committee of some type be set up by the proper authorities which will be empowered to spend these funds in any portion of the state where the occasion may arise, and that the

scope of the application of these funds be widened sufficiently to aid in the care and training of cerebral spastics.

Signed: Earl D. McBride, M.D., Chairman
C. A. Traverse, M.D.
W. P. Fite, M.D.

REPORT OF COMMITTEE ON MEDICAL ECONOMICS

Mr. Chairman:

Your Committee on Medical Economics wishes to make the following report and suggestions:

OKLAHOMA PHYSICIANS SERVICE For Medical and Surgical Care: The Oklahoma Physicians Service began operation in this State on June 1, 1945, and now has 1,600 members.

THE BLUE CROSS: The Blue Cross has been operating in Oklahoma for five years and has a membership of 115,000. The Oklahoma Physicians Service will operate only in counties where the project has been endorsed by the County Medical Society.

This Committee suggests that every County Society take this matter up and endorse the Project at an early date.

Signed: H. K. Speed, M.D., Chairman
C. B. Sullivan, M.D.
John H. Plunkett, M.D.
F. W. Boadway, M.D.

REPORT OF MEDICAL ADVISORY COMMITTEE TO VOCATIONAL REHABILITATION

The Medical Advisory Committee was organized and had its first meeting in August of 1944. Since that time meetings have occurred at monthly intervals except August and September of 1945. The functions of the Committee are defined as follows:

1. To interpret to the State Board the thinking and attitude of the medical profession toward a public-supported program of medical care.

2. To interpret prevailing conditions, policies, and practices which might affect the operation of such a program in Oklahoma.

3. To advise the State Board in the development of policies and procedures to be followed in administering the program, in order to assure the full support of the medical profession, which is essential to its successful operation.

4. To interpret the program to the medical profession within the state in order that there may be a proper understanding of its purpose and its method of operation.

It is by mutual agreement of all members of the Committee that every reasonable effort be made to preserve the private doctor-patient relationship in all cases. The patient or his family physician shall select consultants when his practice is consistent with accomplishing the purposes for which examination is being made.

Consultants are now limited to medical doctors, members of the Oklahoma State Medical Association, who are accredited by the various American Boards or members of the American College of Physicians and the American College of Surgeons. Extension of the Panel of Consultants has been discussed, but no action has been taken thus far.

A tentative fee schedule for examinations and other medical and surgical attentions has been the topic of discussion for several months. This fee schedule is submitted for proper approval, subject to changes in detail as time or circumstances require.

Respectfully submitted,
Signed: Clinton Gallaher, M.D., Chairman
Bert F. Keltz, M.D.
James O. Asher, M.D.
Ennis Gullatt, M.D.
John C. Perry, M.D.
Fred O. Pitney, D.D.S.
Harry Smith

REPORT OF THE COMMITTEE ON MILITARY AFFAIRS

The Committee on Military Affairs met in the Skirvin Hotel on the 7th of October, 1945, and offer the following for your consideration:

1. That the Oklahoma State Medical Association go on record sponsoring the deferment of pre-medical students if they signify their willingness of serving in the armed forces if necessary.

2. That the State Association assist the returning veteran by:

(a) Encouraging them in finding locations where physicians are needed.

(b) Offering financial support, if needed, to veterans in establishing themselves in rural communities.

3. That the County Medical Societies publish in their local papers notice of the returning veterans and their entering private practice.

4. That a Bureau of Speakers from military installations in the state be available to the County Medical Societies and that the County Medical Societies be urged to take advantage of the services of these men for their local meetings.

Signed: W. C. Tisdal, M.D., Chairman
J. Guild Wood, M.D.
Paul N. Atkins, M.D.
Louis H. Ritzhaupt, M.D.

REPORT OF THE COMMITTEE ON STUDY AND CONTROL OF TUBERCULOSIS

The Committee for the Study and Control of Tuberculosis makes recommendation as program for 1945, the following:

1. More adequate facilities for employees of the State Tuberculosis Sanatoria necessary to reactivate present vacant beds. (Over 300 beds are now closed because of personnel difficulties).

2. Persons receiving aid for dependent children should be compelled to carry out recommended hospital treatment in order to receive such benefit.

3. Provide adequate facilities for proper isolation of the tuberculosis inmates of the state mental hospitals, state prisons, corrective institutions and orphanages; and furthermore, recommends that on admission routine chest x-rays should be taken.

4. We favor the present policy of the State Health Department in conducting mass X-ray surveys throughout the state where such surveys are indicated.

5. Recommend that County Medical Societies have a committee on Tuberculosis for the purpose of stimulating a broader interest in Tuberculosis case finding.

6. More adequate facilities in the field of vocational rehabilitation for the Tuberculous.

The Committee further recommends that copy of this program be sent to the Governor, and to the Chairman of the State Board of Public Affairs.

Signed: J. F. McMurry, M.D., Chairman
E. M. Woodson, M.D.
C. W. Tedrowe, M.D.
F. P. Baker, M.D.
R. M. Shepard, M.D.

REPORT OF COMMITTEE ON CONTROL OF VENEREAL DISEASES

This Committee consisted of Dr. A. R. Sugg, Chairman; and in the absence of Dr. Akin, Major J. A. Cowan and Dr. C. P. Bondurant were asked to sit in the committee. The following subjects were discussed:

THE PRE-MARITAL LAW: The administration of this law has brought up many problems, chief among these was differences of opinion among "licensed physicians" concerning such subjects as infectiousness and interpretation of laboratory reports and communicability.

The Committee suggests some standardization by the State Health Department with reference to these subjects. Also, the Committee suggests the simplification of forms and shortening of reports and the speeding up, if possible, of laboratory reports. Also suggested

is the consideration of the question of duplication and the consulting of more than one physician by the applicant. The Committee feels that a controversy should be avoided and the educational value of this law should be stressed and impressed upon both the public and the doctors.

THE PRE-NATAL LAW: The next point of consideration was the Pre-Natal Law. Complications arising out of this presumably were because of misinformation among the doctors concerning the law itself. It also found in a review of 1,000 Birth Certificates at the Oklahoma State Health Department that 25 per cent had never had a blood test for syphilis, and when the problem was looked in to, it was met with considerable indifference.

In aiding the administration of this law, the Committee wishes to suggest first, that the educational value of the law be promoted and made paramount as an issue and that the help of the Speaker's Bureau be asked and used to further this educational plan.

At this point, the Committee met in conjunction with that on Maternity and Infancy and in common agreed that since congenital syphilis is definitely a preventable disease, every effort should be made to further the early diagnosis of syphilis in expectant mothers. It further suggests that the "licensed physicians" in the state be given a copy of this law and urged concerning its importance. It further suggests that birth certificates be held up or questioned when the law is not complied with. It was also suggested that since the law was fostered by the State Medical Association, that it is felt that this Association is morally obligated to lead in seeing that it functions. Also, if violators continue to fail in carrying out the provisions of this law, the State Medical Association should request the State Health Department to take punitive action.

Signed: Robert Akin, M.D., Chairman

A. R. Sugg, M.D.
W. F. Lewis, M.D.

REPORT OF COMMITTEE ON PUBLIC HEALTH

In the interest of promoting the general health and well-being of the citizens of Oklahoma it is the recommendation of the Public Health Committee that the Oklahoma State Medical Association adopt the following program:

1. To encourage the individual County Societies to become acquainted with local and state public health problems and facilities and to devote at least one program a year to public health and that this policy be commended to the individual Society by the State Executive Secretary.

2. To cooperate in expanding the local public health services throughout the state as provided by the 20th Oklahoma Legislature and as outlined in the A.M.A. 14 Point Program.

3. To endorse the establishment of a School of Public Health at Oklahoma University and to give any possible assistance to so doing.

4. To recommend that the Council plan and inaugurate an educational program which will be designed to acquaint every practitioner with health legislation as provided in the Oklahoma statutes. It is imperative that every physician recognize the importance of observing such legislation as the following:

(a) Prenatal law. Thirty per cent of the birth certificates filed since the passage of this law do not show whether or not Wassermann tests were made.

(b) Communicable disease law. The discovery of cases of early syphilis and gonorrhea is impeded since contacts to V. D. cases are rarely reported.

5. To study and assist in securing the following state legislation:

(a) Recommend complete revision of the food and drug law. The present Oklahoma law is out of date and does not conform to federal regulations and those of adjoining states. And that a committee be appointed by the State Medical Association to set up and draft such a law, particularly paying note to the sulfa and

phenobarbital drugs and enrichment of flour.

(b) Revision of the vital statistics law to conform with the uniform vital statistics act and that the Oklahoma State Health department be required to furnish a miniature photostatic copy of each birth certificate filed to the mother within 60 days.

(c) The formulation of compulsory vaccination law, including smallpox and diphtheria, prior to entering school.

(d) Legislation which will grant the Oklahoma Department of Health the authority to enter any industrial plant for the purpose of making inspections and studies of industrial health problems. At present, the Department of Health is not specifically authorized by law to enter these plants.

(e) Specific legislation delegating authority to the Oklahoma Department of Health to exercise control over the operation of all dairies and pasteurizing plants in the state from a health viewpoint.

Signed: Philip G. Joseph, M.D., Chairman
R. W. Lewis, M.D.
J. B. Hollis, M.D.
Fred Patterson, M.D.
C. C. Young, M.D.

REPORT OF COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Medical Education in Oklahoma, centered in the School of Medicine and Associated Hospitals of the State University, has made progress in the past year in spite of operating with shortage of manpower and other wartime handicaps. Modest expansion in the way of increased hospital facilities has been made, and through the generosity of the last legislature, a very substantial expansion of these facilities will soon be under way.

The Committee on Postwar Graduate Medical Education has formulated three plans for returning medical men who desire refresher courses, formal teaching or residencies. This has been outlined in the report of the Postwar Planning Committee.

The Post Graduate Committee of the State Association is pursuing its very successful campaign to carry high class post graduate instruction to the physicians of the State.

The President, through his Speaker's Bureau is furthering the progress of medical education as well, bringing much needed medical information to the public.

There is a considerable shortage of hospital beds throughout the State as a survey now being made will show. There is urgent need not only of increased hospital space, but of diagnostic facilities in every part of the State. It is believed that the plan fostered by Governor Kerr of a Central Base Hospital located on the grounds of the Medical School, with a system of district hospitals and accessible diagnostic facilities in many communities of the State will go a long way to correct this, and ought to place Oklahoma in the forefront in the way of affording adequate medical care to the populace.

The Committee believes that the future is brighter for medical education and hospital service in Oklahoma than it has been at any time in its history.

Signed: Wann Langston, M.D., Chairman
Tom Lowry, M.D.
J. H. Veazey, M.D.
Sam A. McKeel, M.D.
J. M. Carson, M.D.

Think This Over

A Harvard Professor once confessed to a "growing belief" that the best thing anyone can do, when occasion serves, is to tell what he himself knows; it may be of small value, but at least it is not second-handed.—*Time and the Physician. The Autobiography of Lewellys F. Barker*, p. 3. G. P. Putnam's Sons, New York, 1942.

WHEN *digestive symptoms and general malaise are accompanied by marked downward displacement of the viscera, they are often relieved by ANATOMICAL SUPPORT.*



X-Ray of patient with visceroptosis. (Left) The lesser curvature of the stomach is below the crests of the ilia. (Right) X-Ray of same patient after application of Camp Support for visceroptosis indicating how the viscera is held in a more nearly normal position.

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The roentgenologist may or may not find disturbed conditions in the duodenum... the displaced viscera being the only finding.

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Aisenstadt, E. A.	Picher
Alexander, Robt. L.	Okmulgee
Appleton, M. M.	Oklahoma City
Baker, Roscoe C.	Enid
Barkett, N. F. V.	Oklahoma City
Battenfield, John Y.	Norman
Bednar, Gerald, Jr.	Oklahoma City
Booth, Geo. R., Jr.	Wilburton
Carlock, J. H.	Ardmore
Cowart, O. Hiram	Bristow
Cox, Arlo K.	Watonga
Elkins, M. G., Jr.	El Reno
Ellison, Gayfree	Clinton
Etter, F. S.	Bartlesville
Glasgow, J. G.	Bethany
Gordon, James M.	Ardmore
Greenberger, Edward	McAlester
Hemphill, Paul	Pawhuska
Hinshaw, J. R.	Butler
Howard, Walter A.	Chelsea
Hubbard, John C.	Oklahoma City
Huggins, J. R.	Oklahoma City
Levick, J. E.	Elk City
Love, A. J.	Spavinaw
Lyons, M. R.	Oklahoma City
Matthews, N. S.	Oklahoma City

Mohler, E. C.	Ponca City
Murdoch, R. L.	Oklahoma City
Points, Blair	Madill
Ragan, Tillman A.	Fairfax
Rayburn, C. R.	Norman
Robinson, C. W.	Muskogee
Shadid, Alex	Elk City
Stevens, James W.	Sulphur
Tisdal, W. C.	Clinton
Tool, Chas. D.	Edmond
Tracy, G. W.	Erick
Valliberg, E. R.	Oklahoma City
Waltrip, J. R.	Yale
Wildman, S. F.	Oklahoma City
Wolff, J. P.	Oklahoma City
Wood, J. G.	Weatherford
Yeakel, Earl L.	Oklahoma City

The Good Old Days At Hopkins

At this time, the Hospital Staff was so small that all the members became intimately acquainted with one another. Walking through the corridors one could call every medical man and every head nurse by name, in marked contrast to conditions fifty years later (1941) when I scarcely know more than one in five of those I see in the Hospital dining room at lunch time. We all attended the meetings of the Hospital Medical Society, where interesting cases were presented and newer laboratory findings discussd.—*Time and the Physician. The Autobiography of Lewellys F. Barker. p. 43. G. P. Putnam's Sons. New York. 1942.*

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directed, this delicious food drink supplies liberal quantities of most essential nutrients, as indicated by the table below. Qualitatively Ovaltine is equally valuable; it provides biologically adequate protein, readily assimilated and utilized carbohydrate, well emulsified fat, B complex and other vitamins, as well as essential minerals. Ovaltine proves advantageous both as a mealtime beverage and a between-meal snack. Its low curd tension insures rapid gastric emptying, hence it does not interfere with the appetite for the next meal.

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CARBOHYDRATE	62.43 Gm.	VITAMIN D	480 I.U.
FAT	29.34 Gm.	THIAMINE	1.296 mg.
CALCIUM	1.104 Gm.	RIBOFLAVIN	1.278 mg.
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Medical School Notes

Capping exercises for the University of Oklahoma School of Nursing were held in the medical school auditorium October 1, 1945. Twenty nurses received their caps, which were presented by Miss Kathlyn Krammes, Director of the School of Nursing.

Dr. Patrick S. Nagle, Associate in Surgery, has received a year's leave of absence from October 1, 1945 to October 1, 1946.

Dr. John W. Cavanaugh, Assistant Professor of Surgery, has resigned from the faculty of the School of Medicine, effective October 31.

Extension of leave of absence was granted Dr. Donald B. McMullen, Associate Professor of Preventive Medicine and Public Health, to go with the Army of Occupation in Japan for a survey of schistosomiasis, for a period of about six weeks, starting October 15.

Dr. W. L. Haywood has been appointed as chief of staff of the South Ward, Negro Division, of the University Hospital.

The Board of Regents of the University of Oklahoma recently approved Dr. Alberta Webb Dndley's appointment as Assistant in Medicine on the faculty of the School of Medicine, effective October 1, 1945.

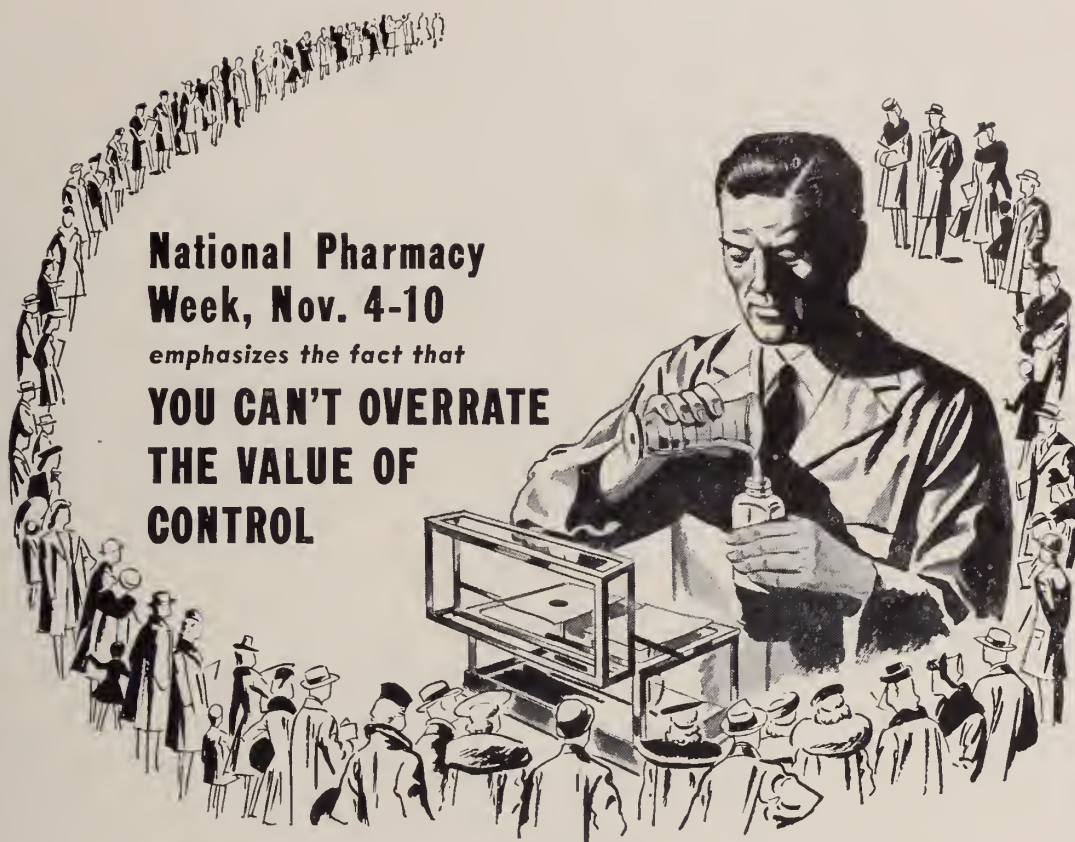
On October 8, 9, 10 the State Board of Dental Examiners met at the School of Medicine to offer dental examinations for state licensure.

Dr. Tom Lowry, Dean of the School of Medicine, attended the annual meeting of the Association of American Medical Colleges, held in Pittsburgh October 29, 30, and 31.

Dr. Floyd Keller and Dr. Howard C. Hopps have recently returned from a trip to Boston in which they attended a post-graduate seminar in legal medicine presented by the Department of Legal Medicine of Harvard Medical School. This was in anticipation of the organization of a Medical Examiner's System in the state within the next few years and the establishment of an independent department of legal medicine at the School of Medicine.

Dr. LeMoyn Snyder, Medical Legal Director of the Michigan State Police, was a visitor at the Medical School Friday, October 26. Dr. Snyder was in Oklahoma City as a guest speaker of the Oklahoma State Bar Association and talked on Medical Criminal Legal Investigation. Dr. Snyder is a member of both the American Medical Association and the American Bar Association. His work in forensic medicine, especially that concerning homicide, has gained for him an international reputation in this field.

The School of Medicine takes particular pleasure in calling attention to the recent monograph, "The Oxidation of Carbohydrates," from the Department of Biochemistry. This is the second of such monographs to be published by this department and represents a most extensive consideration of this important subject. Dr. Everett and his collaborators are to be congratulated on the achievement which has brought such favorable recognition to them and to the School of Medicine.



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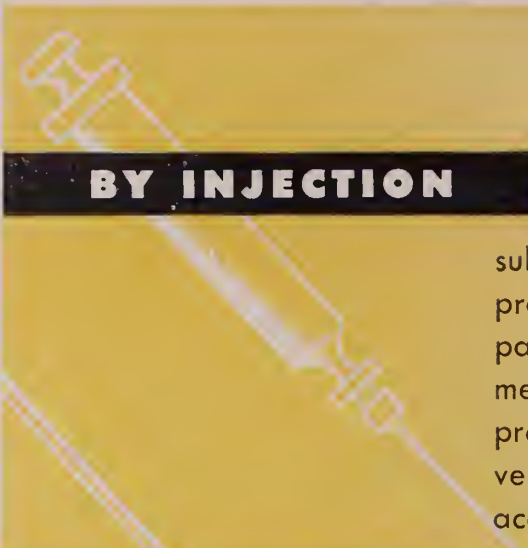
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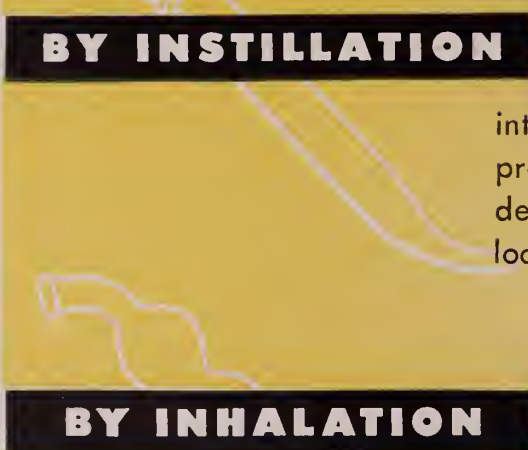
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subcutaneously or intramuscularly, ADRENALIN provides rapid symptomatic relief in asthmatic paroxysms; is useful in the prevention and treatment of other allergic reactions; localizes and prolongs the action of local anesthetics. Intravenously, it is used in shock and anesthesia accidents.




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Book Reviews

TRAUMA IN INTERNAL DISEASES. Rudolf A. Stern, M.D., Assistant Attending Physician, City Hospital, New York City. 575 pages, no illustrations. Grune & Stratton. New York. 1945.

To those who are interested in traumatic diseases and medical testimony, this book will prove to be a revelation. Included in its pages are many case histories which in the mind of the author exemplify the particular diagnosis under discussion.

The text might be called all inclusive since a discussion is made of all of the diseases of the various systems of the body as well as infectious diseases and the relation of trauma as a causative factor in such diseases. It should not be inferred, however, that the author attempts to prove trauma is the cause of all the diseases discussed, yet for some reason they are included.

Throughout the book there appears to be confusion as to cause and effect. There are certain statements made which are founded on unscientific data and which therefore are open to considerable debate. As an instance in point, the statement is made that whereas the traumatic genesis of malignant tumors has never been proven, equally unproved is the assertion that trauma cannot cause malignant growths. Such passages would make excellent material for medical debating societies.

Regardless of what type of the practice of medicine holds one's interest, it is likely that considerable space is devoted to that interest in the book. The one exception to that statement is the true traumatic injuries which the orthopedist usually treats. It is definitely not a book for the orthopedic surgeon.

In a specific way, appendicitis, tuberculosis, peritonitis, diabetes mellitus and chronic nephritis have prominent positions and are quite fully discussed in this volume. To be more specific a case history is given of an appendiceal trauma in a retrocaecal appendix without evidence of injury to either the abdominal wall or the overlying caecum.

To those whose time is taken to a great extent with cases coming before the industrial courts this book is by all means invaluable. That the various ideas in the book and the reasoning involved will obtain general acceptance is extremely doubtful.—*L. J. Starry, M.D.*

THE AMERICAN RED CROSS FIRST AID TEXT-BOOK. Blackstone Company, Philadelphia. 185 pages. 1945.

This attractive, well illustrated, well indexed, revised edition in convenient format prepared for the instruction of First Aid classes deserves favorable mention. Its significance, meaning and scope may be surmised by a glance at the contents listed by chapters. The Why and How of First Aid; Shock; Dressings and Bandages; Wounds and Their Care; Artificial Respiration and the Treatment of Common Asphyxial Accidents; Poisons; Injuries to Bones, Joints, and Muscles; Injuries Due to Heat or Cold; Transportation; First Aid for Common Medical Emergencies; The Human Body — How it is Put Together and How it Works; First Aid Kits.

This well written text with clear-cut descriptions of First Aid in emergencies, with instructive illustrations for guidance, should be not only in the hands of all members of First Aid classes, but in the homes of all good citizens.—*Lewis J. Moorman, M.D.*

WHERE DO PEOPLE TAKE THEIR TROUBLES.

Lee R. Steiner. Houghton Mifflin Company, Boston. The Riverside Press, Cambridge. 1945.

This is a book written about "psychological quackery." The author writes with first-hand information, since her statements regarding imposters who exploit the term psychology are based upon her actual contact with them as a patient and her experiences as consultant

with people who had been victimized by these unqualified practitioners.

Attention is called to the fact that anyone can apparently designate himself as a psychologist. No license is required. Pseudo-degrees such as Ps. D., Ms. D., P.P.d., B.C.S., F.R.G.S., L.T., L.M., B.S.D., F.R.E.S., D.S.B., etc., from "colleges" founded by the quacks are flaunted to the gullible. Exploitation of people suffering with emotional conflict is appalling.

Mrs. Steiner, during 12 years of this research has endeavored to investigate most types of psychological quackery extant in the United States. Those mentioned in her expose included self-styled psychologists, astrologers, fortune tellers, palm readers, Yogas, religious healers, spiritualists, numerologists, radio performers, newspaper columnists, cosmetologists, public speech schools, clairvoyants, hypnotists, vocational guidance quacks, lonely hearts clubs, marriage brokers, trance therapists, graphologists, cosmic ray specialists, taro readers, and other techniques of chicanery.

Among those who have acquired fame and monetary success and who were investigated by the author are, Dale Carnegie, Richard Hudnut Salon, Dorothy Dix, Father Divine, Mala Rubinstein, Elsie Robinson, Saint Germaine, and Phineas Parkhurst Quimby. There are many other less famous, but successful competitors.

The public is admonished by the author to consult a physician, psychiatrist, psychoanalyst, or psychiatrist social worker for advice regarding emotional problems. These professional persons are presumably qualified by special training and the public is likewise presumably protected by the licensure which affirms their ability to aid in such problems that drive people to the exploitation by the quackery that she has investigated. The author recommends that the United States government should really become the supervisor for those who treat these people who take their troubles somewhere. She would have Uncle Sam provide mental hygiene facilities and also the best psychiatric care, vocational study, and rehabilitation by professionally skilled practitioners. Mrs. Steiner advocates group lectures in mental hygiene, distribution of proper literature, and properly supervised radio and moving picture programs.

No one could deny the existence of this unfortunate situation but I do not think it should be the job of Uncle Sam to solve the problem. I would be more inclined toward the opinion that these professionally qualified people begin with the treatment of Uncle Sam. When Uncle Sam has acquired the proper orientation, he then might be given some of the responsibility for supervisory care of these individuals.

One might even consider that the astounding number of patients and pseudo-psychologists could be a symptom of a disorder that has befallen Uncle Sam. I am inclined however, to believe that the symptom is not a serious one. The author's attitude toward the gravity of the situation might be compared to the erstwhile terror of uninformed people of the "seven year itch."

This book is well written. It really presents no particular information not already known by every physician. Possibly some lay people might be helped from heading the book, but my guess would be that even if every person in the United States were to read the book, the quacks about whom Mrs. Steiner has written would still continue to go along. Emotionally distressed people respond in the direction of that which promises most fulfillment of gratifications. Many of them would take most violent issue with Mrs. Steiner, and would defend their exploiters to the very last.—*Coyne H. Campbell, M.D.*

Chicago Medical Society Annual Clinical Conference

The Chicago Medical Society will hold its Annual Clinical Conference at the Palmer House, Chicago, Illinois, March 5, 6, 7, and 8, 1946. All physicians are invited to attend this conference and hear the outstanding specialists from all sections of the country discuss subjects of major interest.

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Women's Auxiliary

The Auxiliary to the Tulsa County Medical Society will meet on November 6th, in the Public Service Club Room. The subject of the meeting will be "Are You Starving Amidst Plenty?" Mrs. I. H. Nelson is in charge. Discussions will be given on "Foods" by Miss Lucile Johnson, and on "Garden Soil" by Mrs. Carl Hotz. Mrs. Embury Hyatt, chairman of the committee in charge of the luncheon, will be assisted by Mrs. H. Lee Farris, Mrs. Frank L. Flack, Mrs. A. W. Pigford and Mrs. W. A. Showman.

Our year-book is just out, and a very interesting program is planned for the coming year.

The December meeting will have an Illustrated Lecture with colored slides on flower arrangements, shown through the courtesy of the Tulsa Garden Club. There will also be a talk by Mrs. N. M. Hulings, featuring Christmas Suggestions.

At the February meeting, Mrs. Goldie Davis will give a talk entitled "How's Your Health." A current health movie will be shown at the Tulsa Public Health Building, with Mrs. S. J. Bradfield in charge.

The topic of the March meeting will be "New Uses of Therapeutics in the Veterans' Hospitals" by a staff member of the Glennan General Hospital.

In April, Dr. Marcella Steel will speak on "Medical Articles in the Current Magazines." At this meeting the annual report will be given, and the election of officers will take place.

At the May meeting, Mrs. Ruth Lundy will give a talk on "Freezing Foods in the New Home Units."

In June, we will have our final meeting, at which time we will have the installation of officers. Music will be furnished through the courtesy of Federation of Music Clubs.

TULSA COUNTY NEWS

Capt. Earl M. Lusk, who has been in the Pacific

for almost 20 months, has landed in the United States and is on his way to the separation center at Ft. Leavenworth. He has been with the 98th Evacuation Hospital fighting at New Guinea, Morotai and Luzon. The 98th was apparently the first Evacuation Hospital group to land in Japan. They went in with the first Cavalry Division and were in the bay during the signing of the peace terms, which they watched through field glasses. Capt. Lusk saw Tojo when he was brought to the 98th Evacuation Hospital for care after trying to commit Hari Cari.

Capt. J. O. Adkins, who expects to be back in Tulsa by the first of January, has recently purchased a new home there.

C. G. (Bud) Stuard, who has recently been discharged, has opened his office in Tulsa.

Lt. Comm. R. G. Ray is with the Naval Recruiting Station in Nashville after spending many months at sea. The late reduction in points makes him eligible for discharge, so he hopes to be back in Tulsa soon.

Major S. E. Franklins writes from Okinawa that during the height of the recent typhoon, he was performing an appendectomy.

Capt. Eric M. White, when last heard from, was on his way to Matsuyama in Japan with an Evacuation Hospital.

Dr. W. R. Turnbow has recently been discharged after having spent 30 months overseas in the Italian theatre.

BEWARE OF THIS FRAUD

A very striking looking well dressed gentleman, 35 to 38 years, arrived in a nearby city and deposited \$450.00 in cash in one of the leading banks. He rented a small office, moved in some equipment, setting himself up as a medical expert. He stayed at a leading hotel. He was a very good mixer and met many people. He soon was able to borrow the use of a good car from a young lady whom he met. He cashed many checks then left by plane, carrying away more than \$2,000.00 in cash, plus a substantial amount of merchandise which he had purchased with bad checks. Up to this time he has not been apprehended.

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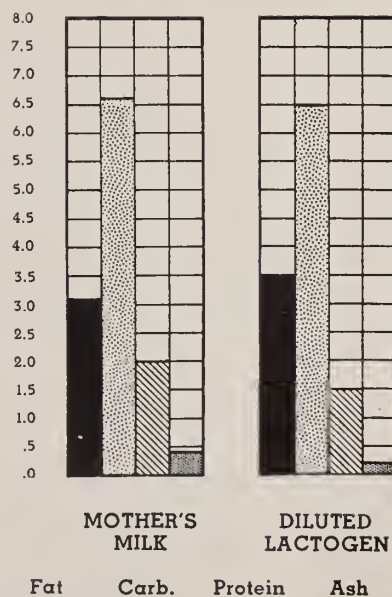
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John Lovett Morse, A. M., M. D.
Clinical Pediatrics, p. 156.



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Obituaries

Malcolm McKellar, M.D. 1885-1945

Dr. Malcolm McKellar died at his home in Tulsa on October 8, 1945 after a year's illness.

Dr. McKellar was born in Green Springs, Colorado on October 24, 1885. He attended Loyola College in Chicago, receiving his Medical Degree in 1913. He interned at the Grace Hospital in Detroit, after which he served as a Medical Officer in World War I. On leaving the service he and Dr. Louis Bremmerman operated the Bremmerman clinic in Chicago. He came to Tulsa in 1922 to become staff urologist at the Springer Clinic.

He was past president of the staff and currently a member of the board of governors at St. John's Hospital. He was also a staff consultant at Hillcrest Hospital.

He was a 32nd Degree Mason, a member of the Akdar Shrine, the Pilgrim Lodge 522, the Chamber of Commerce and the American Urological Association, as well as a diplomate of the American Board of Urologists. He was also a member of the Tulsa County Medical Society, the Oklahoma State Medical Association and the American Medical Association.

Dr. McKellar is survived by his widow, two daughters, two brothers and one sister.

R. K. Pemberton, M.D. 1871-1945

Dr. R. K. Pemberton died September 24, 1945 at his home in McAlester. Although he has been in failing health for the past three years, he carried on with his practice until his death, which was a great shock to his family and friends.

Dr. Pemberton was born March 7, 1871 in Callaway County, Missouri. He received his schooling there, then attended the University of Kansas before entering Missouri Medical College, from which he was graduated in 1895. He began practice in Missouri, later moving to Krebs, Oklahoma.

In 1916, Dr. Pemberton opened his office in McAlester which he maintained until his death.

Dr. Pemberton served as Mayor of McAlester in 1919-21. He was a 32nd Degree Mason, a member of Modern Woodmen of America, Ancient Order of United Workman and the Christian Church. He was also a member of the Pittsburg County Medical Society, the Oklahoma State Medical Association and the American Medical Association. He was held in high esteem throughout Oklahoma.

He is survived by his widow, four children and two sisters.

Classified Advertisements

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When I was seven years old, we moved to a near-by farm that my father had purchased after selling the sawmill and gristmill. He built on this farm a comfortable brick house in which we lived for about seven years. Dr. Norman Bridge, in his autobiography, *The Marching Years*, has an interesting chapter on the educational value to a boy of life on a farm; "the revelations of a single year were a procession of instinctive wonders," he said, and I can testify to the truth of this statement. —*Time and the Physician. The Autobiography of Lewellys F. Barker*, pp. 12-13. G. P. Putnam's Sons, New York, 1942.

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MEDICAL ABSTRACTS

CATARACT AND OTHER CONGENITAL DEFECTS IN INFANTS FOLLOWING RUBELLA IN THE MOTHER. John C. Long and Ralph W. Danielson. *Archives of Ophthalmology*, Vol. 34, pp. 24-27, July, 1945.

Reports of recent years indicate that rubella or German measles during early pregnancy may lead to multiple serious congenital defects in the offspring. In 1941, Gregg, an Australian physician, described an epidemic of rubella caused by crowding and troop movements. After the epidemic, he and others found that many newborn babies had congenital cataracts, and some of them showed congenital heart disease, buphthalmos, microphthalmos, deaf-mutism, and some degree of microcephaly.

The type of defect is somewhat determined by the stage of pregnancy at which rubella is contracted by the mother. On the available evidence, when a woman contracts rubella within the first two months of pregnancy it would appear that the chances of her giving birth to a congenitally defective child are in the region of 100 per cent, and if she contracts rubella in the third months they are above 50 per cent.

Similar observations have been made in New York and in Washington. The author himself observed six such cases. In all six cases rubella had developed in the mothers during the first two to six weeks of pregnancy. The disease was mild and regarded as trivial. In all cases there was a history of contact with some one suffering from rubella and in several cases there were multiple infections in the family. All of the babies had congenital cataracts. In three cases the cataracts were bilateral and the lenses more or less completely opaque. There were three bilateral and three unilateral cases of microphthalmos. In the unilateral cataracts cases the apparently healthy eye showed diffuse pigment alteration in the fundus suggestive of changes resulting from chorioretinitis. One baby has vitreous opacities associated with the fundal changes. Pupillary reaction also behaved abnormally in some cases. All these intraocular findings can be explained on the basis of an intrauterine inflammation involving particularly the uveal tract.

Heart lesions was also present in all six babies, and a septal defect was suspected in four of them. One had talipes valgus, and cryptorchidism. But the most common defect is cataract and microphthalmos. It is now suspected that rubella probably underwent some changes in its general character in recent years, because formerly no one noticed such congenital defects in connection with this infectious disease. It may be also possible that the rubella virus developed new characters in Australia, and this changed virus was introduced to America and the United States.

In view of the great danger to the offspring, it is suggested that girls should be infected with rubella while in their girlhood, so that they would be immune against the infection during pregnancy. It is also recommended to use convalescent serum for preventive treatment of pregnant women during a rubella epidemic. Therapeutic abortion may be also considered if rubella would attack a pregnant woman during the first third of pregnancy.—M.D.H., M.D.

THE AETIOLOGY OF TRACHOMA: A CRITICAL REVIEW OF PRESENT KNOWLEDGE. J. O. W. Bland. *The British Journal of Ophthalmology*, Vol. 29, pp. 407-420, August, 1945.

At present there are only two theories as to the etiology of trachoma: the virus theory and the rickettsial theory. In fact, they are one and the same theory, depending upon what one calls virus and what one con-

siders rickettsia. The evidence shows that trachoma is a specific infectious disease due to a filter passing agent which is almost certainly identical with the elementary and initial bodies found in the inclusion bodies.

Much of the etiological knowledge regarding trachoma is based upon experimental research upon animals. Trachoma can be conveyed to apes and monkeys, but other animal species are insusceptible. Yet, the disease produced by inoculation in apes is not identical with human trachoma; inclusion bodies are very rarely found in scrapings of the conjunctiva; no follicles are ever formed on the tarsus, except on the fornices; there is no vascularization (pannus formation) on the cornea, and the conjunctiva does not show subsequent scarring.

These are the very cardinal diagnostic signs upon which the differentiation of human trachoma from other conjunctival diseases is based. The situation is further complicated by the fact that there is a non-trachomatous follicular disease of the conjunctiva both in man and many other animals, e. g., in rabbits, chimpanzees, and lower monkeys. In approximately one-third of the cases this disease is indistinguishable from a reaction to inoculated trachoma. This circumstance makes animal experimentation less conclusive. It has been therefore urged that negative result should never be accepted as evidence.

It is not doubted, however, that trachoma is a specific disease. It is certain that inoculation of trachomatous material in healthy human beings will produce trachoma. Out of 108 human volunteers, 73 became infected after experimental inoculation, 63 per cent. The failure to contract trachoma was perhaps due to material for inoculation having been taken in a late, non-infectious stage of trachoma, and to resistance of the individual.

The infectious agent is not a cultivable bacterium. No bacterium has yet been shown to produce trachoma when experimentally inoculated into man. The Noguti-type of *Bact. granulosis* is not an agent of trachoma. The trachoma agent is filterable. Filtration experiments, however, are open to criticism since the filter material is apt to absorb much of the virus so that nothing will be found in the filtrate.

In the case of most viruses which form elementary bodies there bodies are now accepted as being the virus itself. In case of trachoma, which shows both inclusion bodies and elementary bodies, it may be also accepted that the elementary bodies represent the trachoma virus itself. But, conclusive proof of the virus hypothesis could only be obtained by reproduction of the disease with purified suspensions of elementary bodies. It seems unlikely that such suspensions will be made so long as we have to use material from human conjunctiva.

The rickettsial theory of trachoma has been put forward in two forms: (1) Rickettsial bodies can be demonstrated in trachomatous tissues which are the cause of the disease and are distinct from the initial and elementary bodies; (2) The initial and elementary bodies are the cause of trachoma and are themselves rickettsiae and not virus bodies.

At present the second version of the rickettsial theory seems to have the most evidence for its validity. It is further strengthened by the occurrence of a positive Weil-Felix reaction in trachoma, and the evidence for transmission of trachoma by lice. Yet, in the positive Weil-Felix reactions the titer does not rise above 1/100 in the majority of trachomatous cases. The statement that rickettsiae from trachoma multiply in the louse cannot be accepted as true evidence for the rickettsial



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origin of trachoma. The agent can survive in the louse and retain its infectivity, however. No evidence has yet been produced that in nature lice are vectors of the agent of trachoma.

The author himself considers that the agent of trachoma stands in an intermediate position between rickettsiae and the large viruses and may possibly form a biological link between them. For the present, it is preferred to group them with the viruses but to give them a distinctive position as the basophilic ciruses on account of the blue staining of their initial bodies and of the matrix of their inclusions which distinguishes them from the larger typical viruses which do not possess blue initial bodies and whose inclusions are acidophile.—M.D.H., M.D.

NASAL SINUS PAIN CAUSED BY FLYING (THE SYNDROME OF SINUS BAROTRAUMA). J. E. G. McGibbon. *The Journal of Laryngology and Otology*. Vol. 59. pp. 405-427. November, 1944.

Sinus barotrauma is a condition in which pain, occasionally accompanied by other symptoms and clinical signs, develops in the frontal region or over the cheek during or shortly after a flight in aircraft. It is caused by a difference between the pressure of the air contained within one or more of the nasal sinuses and that of the atmosphere. Inequality of pressure is brought about by change of altitude in presence of some other contributory factor which causes occlusion of the sinus ostium.

The incidence of this condition is hard to determine since the contributory factor may be clinically more important, and may overshadow the sinus pain caused by change in atmospheric pressure. A difference of pressure of the air contained within the sinus and that of the atmosphere will result if the sinus ostium is occluded by any developmental or acquired formation which may act as a valve. The contributory factor may be developmental such as a developmental valvular fold of mucous membrane, or pressure by a deviated nasal septum,

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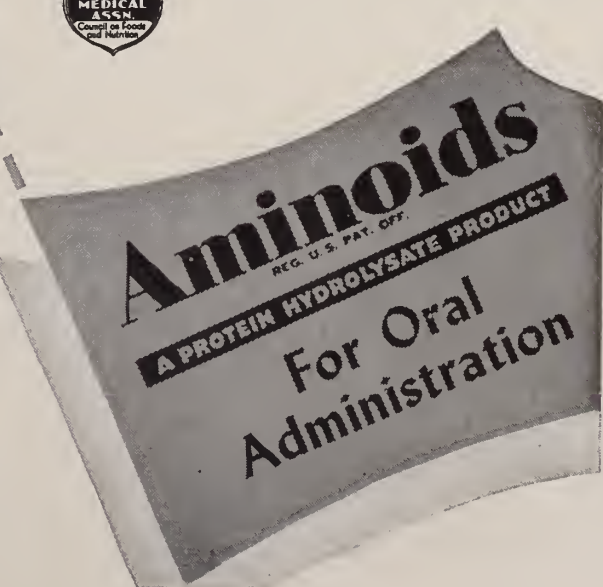
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**McGee, L. C., and Emery, E. S., Proc. Soc. Exptl. Biol. and Med., 45,475 (1940).



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middle turbinate or ethmoidal cell; it may be traumatic as obstruction due to traumatic intranasal deformities; or it may be allergic, as swelling of the mucosa, polyposis, or both; it may be infective as acute or chronic complicated rhinitis, hyperplastic, serous, or mixed sinusitis; it may also be a tumor obstructing the sinus ostium.

Pain is usually the only symptom. A few patients complain of lacrimation, nasal discharge or of a sucking noise high up in the nose. The pain is usually sudden in onset, and of severe intensity during descent, and of more gradual onset and less severity which it occurs during ascent. It may be so disabling that the trip has to be abandoned. It originates above and behind the eyes, and spreads over the vertex to the temporal regions and down the face to the upper teeth. It may persist even after landing, or recur on and off for several hours afterwards.

In some cases there has been copious non-purulent discharge from the nasal fossae during the attack, and in one case there was gross hemorrhage into the sinus cavities. Tenderness on pressure on the floor of the frontal sinuses was present in a few cases. Radiological examination gave reliable information of the presence of a sinus lesion, and it showed some abnormality in a number of cases (thickened mucosa, polypi, etc.) In a few cases it was possible to examine the sinus mucosa histologically, but the changes were not different from those seen in ordinary infective sinusitis.

Prophylaxis comprises careful rhinological selection of aviators and the avoidance of flying while suffering from an acute or chronic upper respiratory infection. The prognosis is favorable.—M.D.H., M.D.

LATE SECONDARY TONSILLAR HEMORRHAGE: STUDIES OF PROTHROMBIN AND VITAMIN K. Harry Nievert. *Archives of Otolaryngology*. Vol. 42. pp. 14-18. July, 1945.

Tonsillectomy and adenoidectomy are not infrequently complicated by secondary hemorrhage occurring generally on the sixth or seventh day. Little was known etiologically concerning its occurrence. The author studied certain

components of the blood, especially the factors involved in clotting and healing. It was also found that secondary hemorrhage after tonsillectomy is less frequent in other countries. In the United States it is customary to prescribe acetylsalicylic acid for the postoperative management of the operated patient. In other countries, especially in Central Europe, aminopyrine is the drug of choice.

It was found that in a series of patients who did not receive acetylsalicylic acid after operation there was no secondary hemorrhage. Other scientists showed that salicylic acid and sodium salicylate administered repeatedly or even in single doses, orally or intravenously, induces hypoprothrombinemia in experimental animals which were kept on a ration low in vitamin K. The animals could be protected against this action of salicylic acid by administration of vitamin K preparation.

Hypoprothrombinemia was also reproduced experimentally in man. In children who received sodium salicylate for treatment of rheumatic fever prolongation of prothrombin time was observed. Other observations also showed that the oral administration of acetylsalicylic acid and sodium salicylate to human beings in daily doses of 1.3-5.3 g consistently produced hypoprothrombinemia and hypocoagulability of the blood. It was assumed even that the not unusual hemorrhagic manifestations of acute rheumatic fever are due not to the disease but to the administration of salicylates.

It seems therefore that administration of salicylates after tonsillectomies and adenoidectomies could completely explain the tendency to postoperative secondary hemorrhages. Hypoprothrombinemia interferes with coagulation. The author's investigations showed that in some subjects a total daily dose of 2.4 g of acetylsalicylic acid will produce an elevation in prothrombin time on the very next day, whereas in others it will be much longer before a significant rise will be discernible. It seems that the promptness of response depends on the nutritional intake and the reserves of vitamin K of the subject.

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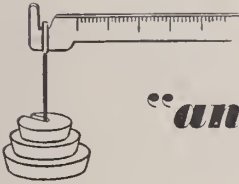
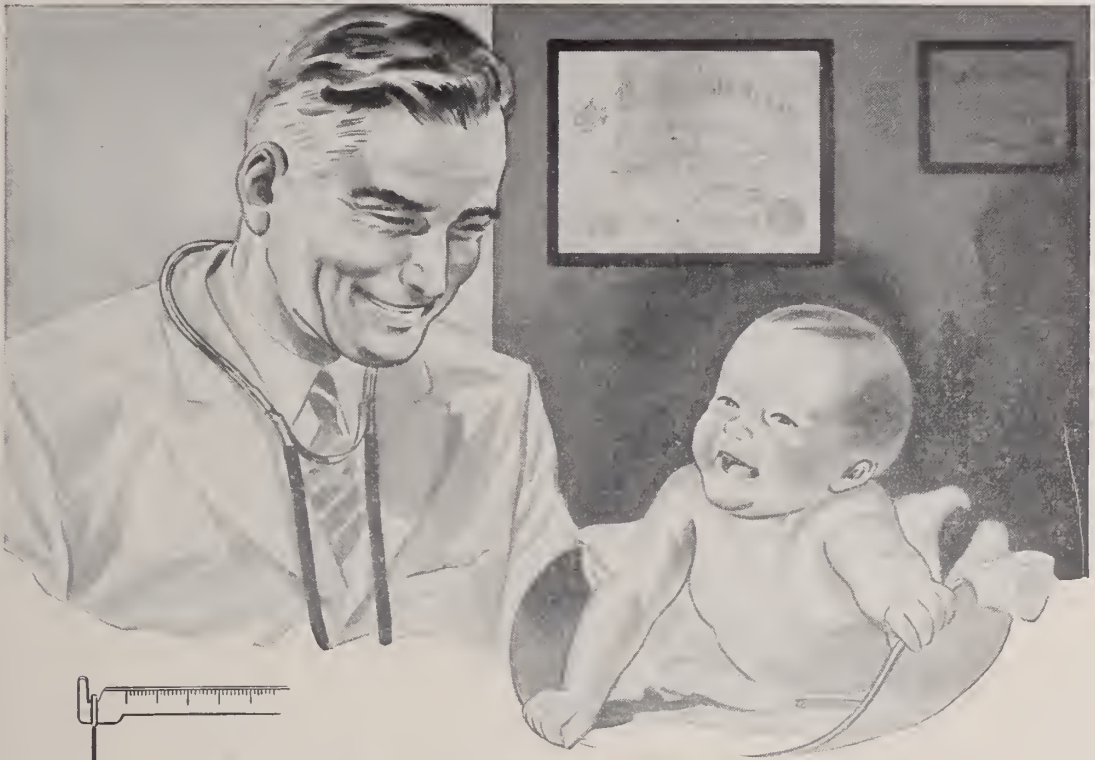
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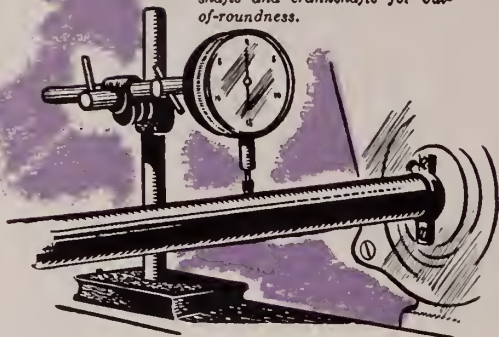
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CAUSES OF DEAFNESS IN FLYERS. Edmund P. Fowler. *Archives of Otolaryngology*, Vol. 42, pp. 21-32. July, 1945.

A frequent type of deafness results, both among passengers and crew, from a change of pressure in the middle ear following improper function of the eustachian tube during and after descent. This has been called otitic barotrauma. If infection is present in the nasopharynx, or in the middle ear, otitic barotrauma may produce suppurative otitis media, called aero-otitis. It is usually bilateral. Pain and exudation of fluid may not appear until several hours after flight. This is called delayed aero-otitis. There is as a rule only slight deafness with aero-otitis.

Quite often, mild nonsuppurative otitis due to barotrauma becomes recurrent, and then it is more apt to last longer and become more severe than with a single attack. The forerunner of chronic aero-otitis is usually chronic nasopharyngitis. From nonsuppurative aero-otitis, either of the acute or of the recurrent type, all kinds of otitis media and mastoiditis may develop. These may clear without residua but often do not.

Deafness which develops while the patient is going up in an airplane is usually transient, but sometimes it remains throughout the flight and may persist afterwards. Its mechanism is probably similar to that of deafness from descent.

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1. Hefke, H. W.: Radiology 42:233, 1944.

2. Bryan, L., and Pedersen, N. S.: Radiology 42:224, 1944.

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Beckham.....	G. H. Stagner, Erick	O. C. Standifer, Elk City	Second Tuesday
Blaine.....	Virginia Curtin, Watonga	W. F. Griffin, Watonga	
Bryan.....	W. A. Hyde, Durant	W. K. Haynie, Durant	Second Tuesday
Caddo.....	C. B. Sullivan, Carnegie	P. H. Anderson, Anadarko	
Canadian.....	P. F. Herod, El Reno	A. L. Johnson, El Reno	Subject to call
Carter.....	J. L. Cox, Ardmore	H. A. Higgins, Ardmore	Second Tuesday
Cherokee.....	P. H. Medearis, Tahlequah	W. M. Wood, Tahlequah	First Tuesday
Choctaw.....	O. R. Gregg, Hugo	E. A. Johnson, Hugo	
Cleveland.....	Iva S. Merritt, Norman	O. M. Woodson, Norman	Thursday nights
Comanche.....	W. F. Lewis, Lawton	W. C. Cole, Lawton	
Cotton.....	G. W. Baker, Walters	Mollie F. Scism, Walters	Third Friday
Craig.....	Lloyd H. McPike, Vinita	J. M. McMillan, Vinita	
Creek.....	C. R. McDonald, Mannford	Philip Joseph, Sapulpa	Second Tuesday
Custer.....	T. A. Boyd, Weatherford	W. H. Smith, Clinton	Third Thursday
Garfield.....	P. W. Hopkins, Enid	John R. Walker, Enid	Fourth Thursday
Garvin.....	Marvin E. Robberson, Wynnewood	John R. Callaway, Pauls Valley	Wednesday before Third Thursday
Grady.....	Roy E. Emanuel, Chickasha	Rebecca H. Mason, Chickasha	Third Thursday
Grant.....	I. V. Hardy, Medford	F. P. Robinson, Nash	
Greer.....	R. W. Lewis, Granite	J. B. Hollis, Mangum	
Harmon.....	W. G. Husband, Hollis	R. H. Lynch, Hollis	First Wednesday
Haskell.....	William Carson, Keota	N. K. Williams, McCurtain	
Hughes.....	H. A. Howell, Holdenville	Imogene Mayfield, Holdenville	First Friday
Jackson.....	C. G. Spears, Altus	E. A. Abernethy, Altus	Last Monday
Jefferson.....	F. M. Edwards, Ringling	J. I. Derr, Waurika	Second Monday
Kay.....	Dewey Mathews, Tonkawa	G. H. Yeary, Newkirk	Second Thursday
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Number 12

The Management of Surgical Complications of Appendicitis*

VIRGIL S. COUNSELLOR, M.D.

Division of Surgery, The Mayo Clinic
ROCHESTER, MINNESOTA

The management of acute appendicitis without perforation is not a serious surgical problem today. It is well known, even by the laity, that the acutely diseased appendix should be removed, but the chief problem is the management of the complications which follow a ruptured appendix. The mortality rate following appendectomy for acute appendicitis in most hospitals is less than 1 per cent, and there are series of several hundred operations without a fatality. Dixon¹ from the Mayo Clinic has reported 437, Miller and his associates² from Cook County Hospital, Chicago, 629, and Stafford and Sprong³ from Johns Hopkins Hospital 838 operations for acute appendicitis without a fatality. The mortality rate in cases of acute perforative appendicitis up to the year 1940, when the sulfonamide drugs were introduced, varied from 15 to 20 per cent. After the introduction of these drugs this mortality rate decreased to 5.1 per cent in 1940 and 1941, and to zero at the Mayo Clinic in 1942.

Obviously, the management of acute appendicitis has two objectives: first, the prevention of complications and, second, vigorous treatment of complications when they do present themselves. With regard to the former, much has been said about early diagnosis and surgical treatment. The public in general is about as alert as the physician. It is not uncommon for a patient to come to the office stating that he believes he has acute appendicitis. Such an action is ample proof of the effectiveness of the campaign to educate the public against the dangers of self-medication, such as purgation, for stomach ache. The scientific lectures for public consumption on the symptoms and dangers of

acute appendicitis which have been sponsored by medical organizations have contributed much in reducing the interval from the onset of symptoms until treatment is sought. A few hours' delay is so likely to mean perforation, abscess and peritonitis. Patients who are having an abdominal operation for some other condition frequently insist that their appendix be removed so that they need not worry about it any more. That is an excellent trend and one which we as physicians should not undervalue, for the many different manifestations of acute appendicitis can be misleading and perforative appendicitis and peritonitis occur when they are not suspected. How, for example, can the following incident be explained?

A farmer, who was in excellent health was walking behind his plow. While turning his plow at the corner he suffered a severe stabbing pain in the right lower quadrant which threw him to the ground; pain such as this occurs in a perforated peptic ulcer. However, at operation two hours later the appendix was found to be perforated and gangrenous throughout.

Acute, purulent appendicitis may exist for two or three days without producing obvious symptoms other than diarrhea, but if the physician takes sufficient time for the examination, tenderness in the cecal region can be elicited by gentle palpation, and palpation may produce nausea.

In order to prevent complications surgeons are justified in exploring the appendix in cases in which acute appendicitis cannot be ruled out, particularly if one or two symptoms strongly point to disease of the appendix. When an inflamed appendix is superimposed on the right ureter, it will cause blood

*Delivered at Oklahoma City Clinical Dinner, Monday, November 26, 1945, in Oklahoma City, Oklahoma.

in the urine and a delay in diagnosis and complications may result. I wonder how often acute disease in an appendix which is retro-peritoneal and extends upward along the ascending colon is diagnosed as acute cholecystitis? The prevention of complications, therefore, simply reduces this question to one of early recognition and removal of the acutely inflamed appendix.

The complications of acute appendicitis which must be considered have been classified in various ways by different authors. They fall into three groups: (1) Acute perforative appendicitis with diffuse peritonitis; (2) acute perforative appendicitis with abscess and (3) postoperative complications, such as residual abscess in the pelvis, subphrenic or subhepatic abscess, intestinal obstruction, paralytic ileus, fecal fistula, appendicovesical fistula, thrombophlebitis and pulmonary infarction.

Before I consider the management of these different groups of complications, it seems important to state that the year 1940 marked the beginning of a new era in the management of complications. In that year the sulfonamide drugs were introduced, and now, in addition, penicillin and streptomycin have been made available. What further therapeutic agents will be used in the management of peritonitis and its sequelae in the future, no one knows. Furthermore, much has been learned in the last five years about the disturbed physiology in these sick individuals, about the value of water balance, about the value of more liberal transfusions of blood and the use of plasma when the albumin-globulin ratio is disturbed. All of these factors have brought about a tremendous reduction in the mortality rate.

MANAGEMENT OF ACUTE PERFORATIVE APPENDICITIS

The real surgical problem now is the treatment of acute perforative appendicitis with various degrees of peritoneal soiling. This problem perhaps is somewhat more perplexing than before sulfonamides were used. It seems evident now that when diffuse spreading peritonitis occurs, there is no tendency for the omentum or bowels to wall off the perforated appendix. In other cases, in which the appendix is perforated, however, the omentum seems to be forming a protective wall around it. In the first group, immediate appendectomy is required, while in the second group operation should be delayed. It is difficult to separate some of the cases into the proper groups. If there is a mass in the right lower quadrant of the abdomen with localized tenderness only, without much systemic reaction, the problem becomes simple. But diffuse, generalized abdominal tender-

ness with considerable systemic reaction indicates continued contamination from a leaking appendix and poor resistance on the part of the host. It is in this group that the greatest reduction in mortality has taken place since 1940. Prior to 1940 many of these patients who were first seen twenty-four to forty-eight hours after perforation had occurred were considered too ill for surgical interference and were given the Ochsner treatment. Today such patients can be safely and more judiciously treated by immediate operation. The method of procedure seems fairly well standardized throughout the country but with some variations according to personal preference.

Briefly, our plan at the clinic in perforative appendicitis without localization of peritonitis consists of (1) immediate removal of the appendix. (2) placing 5 to 10 gm. of sulfanilamide into the peritoneal cavity and (3) general supportive measures depending on the severity of the infectious process and the patient's resistance. In general, each twenty-four hours for seventy-two hours we administer intravenously 2,000 to 3,000 c.c. of 5 per cent solution of glucose in 1 per cent physiologic saline solution containing vitamin C. Transfusions of blood and plasma may be required when toxemia is severe. The value of sulfanilamide in this type of case was especially evident in a recent case.

A young man was submitted to operation for a ruptured appendix about twenty-four hours from the onset of the initial attack. The appendix had perforated near its base and thin fecal material was flowing from the perforation and spreading throughout the peritoneal cavity. The appendix was removed, the cavity cleansed with saline solution and 15 gm. of sulfanilamide was sprinkled over the coils of intestine and down in the cul-de-sac. The wound was closed without drainage. The patient did not become ill, his temperature and pulse remained normal and he was out of bed on the third day and out of the hospital on the eighth day after operation. In the pre-sulfonamide era death surely would have ensued.

The choice of anesthesia for patients of this type is important. A patient who has generalized peritonitis should not be subjected to general anesthesia if it can be avoided, since toxemia is already severe. Local anesthesia alone in my experience is inadequate and time consuming. Spinal anesthesia is ideal because it produces complete relaxation and a quiet abdomen. Spinal anesthesia combined with a small amount of pentothal sodium for nervous patients or patients who request to go to sleep is most useful. For small children, general anesthesia, with ethylene or nitrous oxide with a small amount of

ether is preferable.

The group of patients who have acute appendicitis associated with a mass in the region of the cecum and without evidence of a spreading peritonitis may be treated conservatively. The fact that there is a mass indicates that the inflamed appendix is being excluded from the peritoneal cavity by omentum and intestines. At the clinic the the procedure is to delay operation until the abscess is well formed, which usually is within five to ten days. Then the abscess is drained cautiously through a McBurney incision. Within six to eight weeks when the patient is entirely well, the appendix should be removed preferably through a right rectus incision. Sulfonamides are used routinely in the abdomen and in the wound.

The care of the appendiceal stump is important in prevention of postoperative complications. This may seem to be entirely an academic or controversial question which was settled long ago. Most surgeons consider that the stump of the appendix should be buried and covered well with peritoneum. Some of my associates and I, however, only ligate the base of the appendix after crushing it with a clamp, apply pure carbohic acid to the mucosa and drop the base of the appendix back. I have performed several thousand appendectomies by this method and never have had a stump blow out or a death occur from peritonitis from this source. Necropsy performed in cases in which death had occurred from other causes has revealed that the stump handled in this fashion is superior to any other. Most all surgeons have observed death from generalized peritonitis on the eighth to the tenth post-operative day after inversion of the stump following uncomplicated appendectomy. The peritonitis originates from a small perforated abscess in the wall of the cecum. Management of the stump, however, is not so important a matter in simple acute appendicitis as the low mortality rate now shows, but it is definitely important when induration has extended to the wall of the cecum. The stump of the appendix in this type of case cannot be inverted with safety without risk of a fecal fistula or localized abscess. W. J. Mayo was one of the first to point out the advantage of the ligneous appendix of cutting through the serosa and musmularis of the base of the appendix and ligating only the mucosa. Not a single stitch is placed in the cecum.

Acute appendicitis in children, it seem to me, is a bit different from that seen in the adult. Perforation and localized or general peritonitis occur more rapidly and children become tremendously sick from peritonitis, especially if operation is delayed because of some question of localization. Children at this

critical stage will tolerate removal of the appendix much better than an adult. Miller reported a mortality rate of 13 per cent for the operative treatment, as against 80 per cent for conservative management in 1939. Now with the use of chemotherapy at the time of operation, the mortality rate can be reduced to approximately zero. The introabdominal complications have been reduced greatly also.

I wish to emphasize one other point with regard to appendicitis in children and that is the surgical approach. The cecum and appendix in many children less than five years of age have not rotated completely and descended to the right lower quadrant of the abdomen. Instead they may be found at the hepatic flexure or opposite the umbilicus. The McBurney incision is inadequate, so a right midrectus incision is much more advantageous.

The care of the abdominal wound in the presence of peritonitis and fecal contamination is particularly important. This has been stressed by Meyer⁴, whose experience in the treatment of infected abdominal wounds exceeds that of most other surgeons. He advised that these wounds be treated by the same principles at contaminated traumatic wounds. That is, the wound should be cleansed thoroughly with saline solution and then saturated with sulfonamide, preferably sulfaguanidine, which promotes the highest incidence of primary healing. Also, he recommended the use of fine (0.008 inch or 2.03 mm.) nickel chrome alloy steel wire for fascial closure. However, since the introduction of sulfonamides sever infection of wounds is so rare that sloughing of tissue is uncommon and the use of wire has been discontinued to a great extent.

SEQUELAE OF ACUTE PERFORATIVE APPENDICITIS

The sequelae of acute perforative appendicitis become the main problem in further reduction of the mortality rate. These are mostly intra-abdominal abscesses, principally, pelvic abscess and subphrenic abscess. Intestinal obstruction is a close second. Pelvic abscess and subphrenic abscess. Intestinal obstruction is a close second. Pelvic abscess is by far the most frequent and its surgical care varies in the two sexes.

The onset of an abscess in the cul-de-sac is indicated by pain low in the abdomen, fever, sweats, high sedimentation rate and leukocytosis. Some of these abscesses resolve and others perforate spontaneously into the rectum. The appropriate time for surgical interference must be selected judiciously. It is best to wait until there is plenty of fluctuation and the top of the pelvis is well protected by omentum and bowels. In the male

pelvic abscesses must be drained through the rectum or extraperitoneally through a low inguinal incision. Rectal drainage is accomplished by placing a long curved forceps carefully in the center of the rectal bulge and cautiously forcing an opening through the rectal wall. A small rubber tube placed through this opening for twenty-four to forty-eight hours usually gives sufficient drainage.

Drainage through the cul-de-sac in the female is the method of choice. The posterior lip of the cervix is grasped firmly with a tenaculum and pulled upward. A Sims speculum is used to hold the posterior vaginal wall and perineum down. The vaginal wall is then incised with a knife in the region between the uterosacral ligaments. A long curved forceps is used to enter the abscess. This approach was recommended by McGuire⁵ recently as being applicable in the case of a female child who has a pelvic abscess. A small cylinder speculum will permit visualization of the tiny cervix and it need not be grasped with a tenaculum. A long pointed forceps or probe can be easily pushed through the thin tissues beneath the cervix and adequate drainage is accomplished in this way. This method is superior to rectal drainage.

Subphrenic abscess is a rare complication of appendicitis since the introduction of sulfonamides, but it should be suspected if there is evidence of continued sepsis without localizing signs. The most reliable evidence in the early stages is consovertebral tenderness and daily chills and fever. The temperature curve is diagnostic when it shows a sharp rise to 102 degrees or 103 degrees F. and a decrease to below normal each day. In about a week roentgenologic evidence becomes of real value. It is strongly urged that both anteroposterior and lateral roentgenograms be taken with the patient in the erect position. These will indicate the exact location of the fluid level. The patient who has a subphrenic abscess should be observed carefully and adequate supportive measures used. Many of these lesions will resolve without surgical drainage. If the abscess does not resolve drainage should be instituted but not until the abscess is well walled off. Several days must elapse after the onset of the fever before the walling off is complete. I advise against aspiration because clinical signs will give you as much information and are much safer.

The best surgical approach to a subphrenic abscess consists of resection of the twelfth rib. An incision is made through the bed of the resected rib and the pleura is retracted upward. The kidney can be retracted down-

ward and by blunt dissection the edematous tissues around the abscess and adjacent to the diaphragm are visualized. The abscess then is entered easily. A subphrenic abscess that is on the right and placed anteriorly can be drained through a subcostal incision passing through the rectus muscle and transversalis fascia. The peritoneum can be pushed downward until the diaphragm is encountered and the abscess drained extraperitoneally.

Intestinal obstruction during convalescence following appendectomy for acute perforative appendicitis is not common but is serious. Any intra-abdominal surgical procedure after peritonitis has developed must be regarded as extremely dangerous. Therefore, measures to empty the small intestine by the Wangenstein method should be started if obstruction is even suspected. Inflammatory obstruction only may be present and if the small intestines can be kept empty, there is a good chance that inflammation and obstruction will subside. The cramplike character of the pain with nausea and vomiting are definite and help in differentiating the distention from that of a paralytic ileus. If 1,000 to 2,000 c.c. of fluids are being withdrawn from the small intestine, adequate quantities of dextrose and saline solutions must be given intravenously. Plasma is useful in preventing edema of the tissues. Determinations of the chemical constituents of the blood must be made daily. Ileostomy is rarely required unless a closed loop obstruction develops.

Paralytic ileus is the most common cause of postoperative abdominal distention but it is not a surgical complication. It responds well to deflation by the Wangenstein method. These patients are not as critically ill as those who have acute mechanical obstruction. Ileostomy never is indicated.

Fecal fistula is not a particularly serious complication but is especially annoying both to the patient and surgeon. Spontaneous closure will occur in most cases if regional enteritis does not exist. Most fecal fistulas following appendectomy are due to an open appendiceal stump or a hole in the cecum. Once operation has been decided on, it must be radical. The best approach is a right rectus incision over the cecum so that the cecum and terminal ileum can be brought outside of the abdomen for inspection and surgical procedures. Occasionally the cecal wall is indurated because of recurring abscesses, so that it is not safe to attempt simple closure of the opening; in such a case it is better to perform ileocolostomy and resection of the cecum and portion of the ascending colon.

The possibility that actinomycosis is the

cause of fecal fistula must not be overlooked. The sulfur bodies are not always found in the drainage but can be found deep in the wall of the abscess. If they can be identified, resection of the cecum and terminal ileum is the surgical procedure of choice. Penicillin is the antibiotic preparation which is specifically indicated. One million units in physiologic saline solution given every twenty-four hours intravenously at a rate of twenty-five drops a minute for four or five days is the dosage recommended. Then the dose can be reduced to 100,000 units daily and administration continued until the end of a ten day period.

Appendicovesical fistula is a rare complication of appendicitis but does occur when least suspected. The orifice of the fistula is in the base of the bladder or low on the right lateral wall. Frequently it is close to the ureterovesical orifice. These fistulas always come some time after the abscess has subsided or has been drained. The diagnostic features are a history of appendiceal abscess, recurring cystitis and passing some gas bubbles from the urethra at the end of voiding. The surgical procedure is transperitoneal closure of the fistula and removal of the appendix. The site of closure of the fistula should be protected by some fat tags or omentum.

Thrombophlebitis and pulmonary infarction are two complications which occur as a rule when the patient is well on his way to recovery and when they are least expected. Thrombophlebitis is such a serious complica-

tion that some surgeons now recommend immediate ligation of the iliac vein on the affected side. For two years I have been giving dicumarol orally, 350 mg. on the third day and 250 mg on the fifth day after operation to patients who are considered likely to have phlebitis. The second dose is not given if the prothrombin time has risen to 50. I am convinced of the usefulness of dicumarol and consider it a valuable agent. The pain of a non-fatal pulmonary infarction is relieved in twenty-four hours after onset, and I have not further infarction and death from subsequent emboli following the administration of this drug.

COMMENT

In closing, I feel I should give great praise to those who perfected the sulfonamides and to Sir Alexander Fleming and his co-workers for developing penicillin, which has proved a most valuable aid in the prevention and cure of surgical complications of appendicitis. The surgical problem has been simplified.

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Elongated Uvula

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Elongated, hypertrophied or edematous uvula is by no means of uncommon occurrence.

Too often an elongated or hypertrophied uvula is overlooked in our search for the causative factor in patients complaining of cough, clearing of throat, nausea or vomiting. The patients may fear a chronic bronchitis or tuberculosis and often consult their physician thinking they have one or the other of these conditions.

Elongation and hypertrophy of the uvula without acute inflammation may be caused by a chronic pharyngitis which is secondary to a post nasal discharge or it may also be the result of excessive use of tobacco or alcohol, over a long period of time. The length

or size of the uvula may vary in that it may be only slightly longer than normal or may be very long and large as in the case reported below.

The edematous uvula is an acute condition and may follow surgery in the pharynx, (tonsillectomy or adenoidectomy) the use of too much alcohol, excessive clearing of the throat or too strong condiments. It is practically always present where there is a peritonsillar abscess.

Treatment is dependent upon the condition found: e. g. the inflamed, elongated uvula, not necessarily edematous, responds to astringents and the elimination of any irritants that may be taken into the mouth.

The uvula that is elongated or hypertroph-

ied and found to be chronic in nature must be treated surgically. This may consist of removal of the tip or the amputation by the method most suitable to the individual case. It is advisable to have the cut surface facing the posterior pharyngeal wall in the case where the tip is clipped off in order that foods swallowed will not irritate the wound and retard healing or produce bleeding. For this I use a cervix scissor which has a tooth at the end of each blade to keep the uvula from slipping out of the scissors as the blades are closed. Casselberry's operation is a good one and consists of making an inverted V shaped amputation of the uvula and bringing the cut edges together with black silk.

The edematous uvula is very annoying, but not too painful to the patient. Sometimes it is necessary to puncture the uvula in many places or clip off the tip but I have found the best treatment is to put patients suffering from this condition to bed and have them lie on their side. This permits the uvula to fall to the side of the pharynx and promptly relieves symptoms.

Recently I saw and treated a case of elongated hypertrophied uvula which I wish to report.

CASE REPORT

M. B., female, age 18, weight 90 pounds. This young lady is small but well developed and well nourished.

The patient consulted me because of a slight pharyngitis. Upon looking into the

pharynx I found she had a uvula which had filled the entire pharynx and was extending downward. I could not see the tip until I pulled the uvula up and forward. She stated it did not interfere with breathing, speech or swallowing.

Upon further questioning I learned I had examined her ten years previously while making a school examination and had found the uvula larger than normal. She had the usual diseases of childhood, but no severe sickness of any nature and practically no sore throat.

All laboratory tests were essentially negative.

Under general anaesthesia the uvula was amputated and found to be four inches long, one and one-fourth inches wide and three-fourths of an inch thick at the base. It was very irregular and nodular in outline. The cut edges were closed with through and through sutures of black silk. She made an uneventful recovery and has had no change in the tone or volume of her voice.

The pathologists report: "Microscopic Examination: Sections from the lesions shows a greatly thickened surface epithelium, beneath the basement membrane the tissue shows leukocytes, increase blood supply and connective tissue. The surface epithelium shows some tendency to irregularity of the cells but it is my opinion that they are not malignant. Micro-Anatomical Lesion: hypertrophy of uvula."

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JOHN W. CAVANAUGH, M.D.—BELA HALPERT, M.D.
OKLAHOMA CITY, OKLAHOMA

DOCTOR HALPERT: The patient whose story we are presenting today suffered from a common disease but one in which a relatively rare complication added much difficulty to the clinical diagnosis and treatment. Doctor Cavanaugh will discuss the clinical aspects of the case.

PROTOCOL

Patient: E. L., white male, age 61; admitted March 28, 1945; died April 16, 1945.

Chief Complaint: Burning, sharp, intermittent epigastric pain for four months.

Present Illness: The patient stated that he was perfectly well until November, 1944 at which time he began to have sour eructations, sometimes accompanied by a burning, sharp intermittent pain in the epigastrium. These occurred either immediately before, or from 10 to 15 minutes after a meal, or, frequently, between midnight and 2 a. m. The pains were relieved by belching or Alka-Seltzer. The episodes increased in frequency and intensity, and the patient ate less in order to avoid them, with the result that he lost weight and strength. In December, 1944, he had an episode of epigastric pain and burning 10 minutes after a meal, became nauseated and vomited the last meal eaten, without gross evidence of blood or bile. The vomiting relieved distress. Spells of vomiting continued to occur once or twice a week for the next three months, with slight variations in intensity. On Feb. 26, 1945 the patient left his home in California to visit a daughter in Oklahoma City. His condition remained unchanged until March 2, 1945, when he did not eat dinner because of epigastric pain and distress. At midnight he became nauseated, went to the bathroom to vomit and fainted. He was put to bed and revived, after which he vomited more than three pints, by measure, of bright red blood and undigested food. He was taken to a local hospital, where he was given three blood transfusions and was sent home on March 14, 1945 with several medicines to take and a diet to follow. No x-ray studies were made. He seemed somewhat improved, but was unable to take all of the prescribed diet. On March 27, 1945, he vomited dark brown par-

tially digested food but no fresh blood. He was referred to this hospital, and was admitted on March 28, 1945.

Past and Family History: Noncontributory.

Physical Examination: On admission the patient appeared emaciated and chronically ill. There was no superficial lymphadenopathy. The pupils reacted to accommodation but not to light (he had received morphine just prior to admission). Teeth were carious. Lung fields were clear. The heart was not enlarged to percussion, sounds were normal, and no murmurs were heard. The abdomen was doughy, with definite muscle resistance. There was thought to be free fluid present. The liver was not palpably enlarged; nor was the spleen. Peristalsis was heard. Rectal examination revealed packing of dry, pale colored feces. Reflexes were normal. Blood pressure was 110/84.

Laboratory Data: On admission the urine was normal except for 1 plus reaction with Benedict's solution, (this was following I. V. glucose). The blood contained 2,760,000 red blood cells, and 27,200 white blood cells/cw. mm., 79 per cent of which were neutrophils and 21 per cent lymphocytes. On March 29, 1945 there were 7.5 Gm. hemoglobin with 3,610,000 red blood cells and 25,000 white blood cells with 93 per cent neutrophils. On April 9, 1945 there were 13 Gm. hemoglobin, 4,510,000 red blood cells and 6,100 white blood cells. On March 30, 1945, N.P.N. was 43 and on April 10, 1945, N.P.N. was 28. Blood sugar (fasting) on April 2, 1945 was 82, calcium was 10.6 mg. and phosphorus 3.2 mg. On April 11, 1945 total plasma protein was 5.1 Gm. per cent with an albumin-globulin ratio of 1/1. Mazzini test was negative.

Clinical Course: Temperature on admission was 101.8 degrees F. Throughout his hospital course he had an irregular spiking fever, with peaks varying from 102, F. to 103.8 F. There were frequent episodes in which he appeared to go into deep shock with blood pressure 70-50/40, and would lapse into unconsciousness. He was placed on an ulcer regimen and was given supportive therapy with parenteral fluids, blood transfusions,

and oxygen. On several occasions he vomited blood and passed bloody feces. A G.I. series on April 6, 1945 was interpreted as carcinoma of the stomach. His course was steadily downhill and he died on April 16, 1945.

DOCTOR CAVANAUGH: Usually the first consideration in a patient whose symptoms are as outlined above is that of *peptic ulcer*. It must be admitted that this man's story is not typical peptic ulcer, but then in cases of proved ulcer, the history is often atypical. It is obvious that this patient did have some lesion in his stomach which bled to considerable extent upon several occasions and furthermore that, since he vomited undigested food some six or eight hours after his last meal on at least one occasion, there was pyloric obstruction. Peptic ulcer is the most frequent cause of massive bleeding from the stomach, at least one-fourth of such cases will exhibit gastric bleeding. The story here is more suggestive of gastric ulcer because (a) he suffered from a massive hemorrhage and (b) the pain was rather vague and relief following ingestion of food was irregular. With duodenal ulcer the syndrome of pain, food, relief is usually pretty definite. *Gastric cancer* must also be considered although it is unusual for cancer to produce a massive hemorrhage such as this man had. In the case of pyloric obstruction without x-ray evidence of a filling defect or niche, three-fourths of the cases occurring in those over 60 years old are on a neoplastic basis. *Cirrhosis of the liver* or *Banti's syndrome* could account for such hemorrhage on the basis of a ruptured esophageal varix but such an instance is almost always accompanied by ascites and splenomegaly, neither of which this man presented. *Syphilis of the stomach* should be considered in all cases such as this because, though rare, it does occasionally occur and is subject to diagnosis and adequate treatment only if and when it is actually entertained as a possibility. The negative Mazzini test is sufficient in itself to practically eliminate this possibility. *Gastric polyposis* was considered but was ruled out by x-ray examinations. One other gastric lesion sometimes concerned in the etiology of gastric ulcer is the presence of a *bezoar*. Such a foreign body can be readily visualized by roentgenologic studies of the stomach.

So much for a differential diagnosis based upon this patient's "present illness." Let's consider for a moment certain specific features of the laboratory data and of the hospital course. The anemia which the patient presented is quite characteristic of an iron deficiency anemia which in this case we can attribute to chronic hemorrhage. Such an impression is based primarily upon the low color index which on March 29, 1945 was approximately .7. The leukocytosis of 25,500

with 93 per cent polys, together with the spiking fever indicates some obscure focus of infection. In cases of this sort, *infection* of an ulcerating gastric lesion (which would be apt to occur only in the absence of free HCL) or necrosis of cancer metastases and "toxic" absorption of the break down products could be responsible but usually produces less fever and less leukocytes. It is noted that two days following admission, the patient's N.P.N. was 43. Even higher values are sometimes seen following massive gastrointestinal hemorrhages attributable to the absorption of blood from the intestine. The determination of plasma proteins is always important in cases such as this in that it indicates the degree of protein malnutrition and is one important index of the patient's ability to withstand operative procedures and his resistance to infection. In this case the value was 5.1 per cent with the bulk of the reduction, as usual, in the albumin fraction. I suspect that careful examination would have revealed beginning nutritional edema. An explanation of the frequent episodes of shock which this patient exhibited was not apparent during life. The final diagnosis, considering the x-ray findings, was rather obvious—carcinoma of the stomach. It is equally obvious, I believe, that such diagnosis must be made at a much earlier time than when this patient first came to the University Hospitals if curative or even significant palliative measures are to be successfully employed.

DISCUSSION

QUESTION: In cases of gastric carcinoma where there occurs extensive hemorrhage are there likely to be high values of hydrochloric acid in the stomach?

DR. CAVANAUGH: Not necessarily. Such a phenomenon can be explained upon the fact that bulky carcinomas outgrow their blood supply so that, in a sense, ulceration occurs spontaneously.

QUESTION: What do you consider the probable cause of the frequent episodes of shock?

DR. CAVANAUGH: It might have been a manifestation of gastrointestinal hemorrhage.

QUESTION: What can be done to bring about a higher curability rate for carcinoma of the stomach?

DR. CAVANAUGH: At present, surgical excision is the only treatment that we have to offer and, although our surgical techniques are becoming more highly perfected we are still faced with the fact that at the time that the diagnosis is made only 20 per cent of these patients are *operable*. Out of these 20 per cent only two or three are curable so that the 97-98 per cent mortality attendant to carcinoma of the stomach is an indication of our inability to make an early diagnosis.

Carcinoma of the stomach will not offer much, insofar as curability is concerned, until we find some method of early diagnosis—diagnosis before spread has occurred to the coeliac plexus, porta hepatis, liver, etc.

ANATOMIC DIAGNOSIS

DR. HALPERT: To consider first the gastric lesion, a large rather bulky carcinoma 9 x 9 cm. in area occupied the distal portion of the stomach extending to but not across the pyloric ring. This presented a large central area of ulceration with evidence of old and recent hemorrhages in the base and margins. This gives adequate explanation for the repeated hemorrhagic episodes, for the anemia, for the pyloric obstruction and for the lack of peristalsis in this portion of the stomach which was the major criterion upon which the roentgenologists based their diagnosis of carcinoma. This location is typical in that approximately 60 per cent of gastric cancer arises in the lesser curvature of the pyloric region. Almost 90 per cent of all carcinomas of the stomach fall into the group of columnar cell or adenocarcinoma and that was the case here. This was a rather well differentiated mucinous adenocarcinoma. It had invaded the entire thickness of the muscular wall but had not yet involved the peritoneal surfaces so that drop metastases or peritoneal carcinomatosis had not occurred in this

case. Extension had occurred into the regional lymph nodes and three rather small discrete metastases were present in the lung. This is not the typical course of metastasis from carcinoma of the stomach for usually the liver is pretty extensively involved before pulmonary metastasis occurs and in this case, there were no hepatic metastases. There was an important lesion in the liver however and one which explains certain of the obscure clinical manifestations. The left lobe of the liver was densely adherent to the posterior wall of the stomach and an area 6x6x4 cm. was converted into an abscess cavity filled with thick light yellow pus. This was at least several weeks old and explains the leukocytosis and spiking fever which this patient exhibited. This infection was further manifest by the "septic hyperplasia" of the spleen which weighed 210 Gm. In addition this patient had a moderate bronchopneumonia and hypostatic edema which certainly contributed to his demise. Regarding the frequent episodes of shock, we found no explanation other than that which Dr. Cavanaugh offered, namely gastric hemorrhage. The fact that these attacks responded to the administration of plasma and blood infusions would further substantiate this. At necropsy there was considerable fresh blood in the lower intestinal tract.



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SPECIAL ARTICLE

MEDICINE AND SOCIAL CHANGES*

ERNEST E. IRONS, M.D.

CHICAGO, ILLINOIS

Vast social changes are under way over the world, and here at home. They had already begun in the last century. They were accentuated by World War I and have been precipitated by World War II. The French Revolution corrected some of the more glaring faults at the top, but failed to ameliorate the lot of the mass of the population. In the political field after each period of war, there have been rearrangements of political and governmental power. Looking back at them now, we see that some were clearly improvements over their predecessors — others seem to have missed goals that would have been of far reaching good had they been extended to reach the masses.

In all ages, economic pronouncements, however excellent, have been modified by the thinking and problems of later times. Even the sound theory and principles of Adam Smith are now criticized as having been influenced by the necessities and exigencies of growing business and of the British Exchequer.

There are now those who, to meet evident faults and weaknesses in our social system, would throw aside all experience and precedent, and change everything to something new without regard to whether the new could be expected to function as planned. They urge a total change in plan in the face of a thousand years of experience pointing the opposite way. And this phenomenon is by no means modern. Algernon Cecil in his *Life of Metternich* describes the situation following the Congress of Vienna: "'Change for change's sake' became as engaging a sophistry in the senate as 'Art for Art's Sake' in the studio, and it had the power, and indeed the purpose, to undermine the best administration in the world. Metternich saw no value in it; nor has it any. It poses as a divine discontent, but it promotes a revolution of destruction."

Today an ever increasing social consciousness, however desirable, tends to become emotional, and this emotional state is at once seized upon by designing leaders to impose, in the name of social justice, impractical and

excessive provisions, which if carried through will wreck present economic living, carrying down with it the beneficent reforms it was made to forward.

Much is made of the shibboleth of "trends" and we are advised that the "trend" now is toward increasing government supervision of individual lives. The argument then proceeds that since this "trend" is progressive and inevitable, we must readjust our laws, and indeed our constitution to agree with the trends. No greater fallacy was ever promulgated than that of the inevitability of trends. For the most part, trends are temporary. In our federal government, the legislative branch was dominant up to the Civil War. Then the judicial branch attained supremacy and for the past 35 years, and especially in the past 15, the executive branch has been dominant. As has been repeatedly pointed out, a "trend" is not a cause of change, but a "register of relative strength." "The very acts of taking thought and acting on the basis of thought are among the factors that determine the future trend of events. (Frank)". It is when the taking of thought is performed by a few self-appointed administrators to the exclusion of the mass of the governed, that an assumed trend becomes dangerous.

The trend toward centralization of government and national economy is not modern. The employment of power of the state to achieve economic ends was one of the characteristics of the 18th Century. In France, under Louis XIV, the lives of the people, their manufactures, the prices of their food, their wages, and as far as possible the details of their daily lives were regulated by laws and bureaus, in the name of order, method, prosperity, and liberty. As President Weiston of Brown University notes, "no modern social service state" devoted to "full employment" could have regarded the "underprivileged" more tenderly. Freedom from want was the ideal. The paternalistic motive was noble; the results miserable." "All these projects for betterment failed of that noble objective, because, however laudable their aims, the means were inappropriate. They were based on the power of the state, not the productive-

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ness of human labor, stimulated by imagination, energized by ambition, challenged by freedom." The solution of our economic problem today is honest work and the development of a sense of personal responsibility on the part of the worker.

In recent years we have seen repeated many of the same stupidities, illustrated by the plowing under of cotton and grain, and the slaughter of little pigs, the creation of an economy of scarcity, the favoring for political reasons of one bloc at the expense of another. The necessities of governmental supervision of economy for the purpose of total war should not blind us to its dangers in peace. The maintenance of free enterprise is as essential to us, as is agreement in world politics to the realization of a safe and lasting peace. "A managed economy tends to war."

We are faced with the alternatives of totalitarianism and managed economy, or of democracy and free enterprise. If we as a nation are as devoted to the cause of lasting peace as we claim to be, we shall hesitate to commit our fortunes and our welfare to the care of the bureaucracies of blocs inherent in a managed economy. The proposed attempt to imposed socialized medicine on the American public is closely allied with and part of an even more serious threat against our American Democracy. The malevolence of the totalitarian wolf loses none of its menace by the sheep's clothing of governmental paternal solicitude.

Propagandists and those with ulterior motives are quick to take advantage of American enthusiasm and susceptibility to over-emphasis. Regions where economic conditions are bad, and where coincidently and perforce medical care is not good, are selected and held out to the public as representing the average American community. Charitable but unthinking and gullible citizens accept such statements and, with the American weakness for overemphasis, are ready emotionally to join a crusade for change, when the real facts are that the American public enjoys the best health and medical care of any nation on earth, far better than many of those countries in which the alleged benefits of socialized medicine have been cited for decades. The decision might be allowed to rest on the fact that the American citizen is better cared for than the citizen of any other country, were it not that socialized medicine is merely another step in a wider and more sinister plan to impose a totalitarian system on all walks of life in this country.

Lest the close analogy of some of our recent economic performances with the economic and social failures of the 18th century be too depressing, it may be noted that in this country there have appeared a few signs

of improvement. The American public is becoming better informed of the real facts concerning medical care. This is reflected in a distinct change in type of *some* legislation proposed in Congress. The politician is interested in being elected. He may have definite personal opinions on an issue, but his vote will be subject to the opinions and votes of the people back home. It will no longer be so easy for unsound economic and social proposals to ride in on the wagon to total war effort.

The claim that draft rejections of 4,000,000 indicate that the American nation is about to fall to pieces and that only a complete plan of government controlled medicine can save us is readily refuted by reference to the specific causes of these rejections. Only a sixth of the 4,000,000 rejections were due to remediable causes. Obviously, illiteracy and feeble mindedness will not be cured by any system of medicine, socialized or otherwise.

Another method of those who would stamper us into unconsidered and radical change is that of partial quotation. The current habit of viewing with alarm in matters medical is satirized by a writer in the New York Times. In order effectively to "view with alarm," he says, it is absolutely necessary when quoting, never to use conditional or supplementary clauses. As an example he cites a syndicated Washington article which quoted a prominent authority on food: "Only one American in a thousand is really well fed." This is surprising and shocking, for most of us had supposed that as a nation we were fairly well nourished. What the quoted writer really said was: "Only one American in a thousand is well fed in the sense that no further improvement in his physical condition could be made by changes in his diet." Our mental shock subsides, although one still might question the practical value of the full statement. Out of such partial quotations the fabric of propaganda is manufactured.

Physicians by virtue of their training and experiences in life are well aware of the necessity of increased efforts to alleviate distress and to improve social conditions among the less favored of our citizens. They are in a position to judge of the prospective efficacy of remedies suggested. They are *also* anxious that the remedies proposed shall not make the patient worse, and tear down the progress he has already made.

The imposition of socialized medicine on a nation which does not want it, will inevitably lead to a deterioration in the average quality of medical care and thus lower, rather than raise, standards of living. Managed medicine is no better than managed economy.

Labor has been told by leaders that social-

ization of medicine will give great benefits which the union workers now do not get. The fallacies in the reasoning of such propaganda are beginning to appear to some of the leaders themselves. Recently there appeared the report of a delegate on his observations in England on The Reception of the Beveridge Report. He said that he was somewhat surprised to find a certain coolness of some English labor representatives toward the medical benefits of the Beveridge Plan and that when he looked into the matter he found that, in point of fact, the worker would get very little for his shilling.

Illustrative of another and less pleasing attitude and a disregard of both economic and professional standards is the reported recent conversation of a prominent labor leader and an industrial physician. They were discussing the proposed socialization of medicine, and the physician asked whether, after all, the plan would not turn out to be more expensive than had been claimed. "On the contrary," said the labor leader, "I can get plenty of doctors to take care of my group for much less money, probably \$3,000 a year." "But," said the physician, "do you not think that the quality of service might suffer? Would you want that kind of service for yourself?" "O well," said the labor man, "of course I would have my own doctor."

Some time ago we were told that "the dawn of the century of the common man" is at hand. The question has been raised as to whether he will like his century after he gets it. This will depend on his education as to true values of quality. He will have to be more discerning than some of his leaders, if he is to avoid disappointment and disillusionment.

By dabbling and, at times wading rather far out, in the dangerous waters of a managed economy, we have not only committed the absurdities of limiting production of food stuffs and of thereby making more expensive the living of those least able to pay, but we have been terrorized by the threats of the alleged dangers of technological improvements in manufacturing. This latter harks back to the same fear of improvement, by workers in textile manufacture in England in the industrial revolution of the late 18th and early 19th centuries. Some time ago we embarked on a program of made work and W.P.A. which soon degenerated into a travesty of work, with shovel leaning as the principal occupation. It is true that this was begun with the avowed intent of allowing people to work and thus to save their sense of pride and independence, but the outcome was the opposite, and it took total war to break the hold of this well intentioned but morally

ruinous habit of total laziness.

And in high circles the tentacles of managed economy have been extended, through the formation of a multitude of federal corporations, many of them responsible to no one but political heads, with capitalization and assets estimated at a tenth of our present enormous public debt, in some instances in contravention of the courts, the constitution and the will of the Congress. So far have we already progressed along the downward path of a managed economy. Socialized medicine is proposed as a further step away from democracy and free enterprise, and toward the authoritarian state, with centralization of power.

Many of the ills, both economic and medical, for which these remedies have been proposed are real and require correction. It will be the kind of cure proposed and its method of application which will either threaten the life of our democracy, or on the other hand, will lead to progressive improvement.

The first step is the renewed recognition that these medical deficiencies are closely linked with economic and social lacks, and that the ills and their remedies vary with different communities. The cure must be individualized.

Such individualization cannot be accomplished by a centralized administration, far removed from the vote of the people concerned. The problem varies with the states, and its attempted solution should not be made the occasion for the abrogation of states' rights. It was for the purpose of preventing a dictatorship that in the framing of the constitution powers not specifically provided for, were reserved for the states. The medical problems of the states can be best understood and provided for by the people who live there.

This process of providing for the increasing recognition of medical and social needs has been an evolutionary one, and has been steadily progressing as medicine has demonstrated its increasing ability to serve. In rural communities, the automobile and paved roads have revolutionized conditions of medical practice, and greatly increased the effectiveness of the local practitioner. Hospitals have multiplied and the physician now has better tools with which to work. One of the present problems is to increase these hospital centers in regions in which an intelligent survey indicates their need. Areas isolated from large centers of population can be given better care by the establishment of a large general hospital which shall serve a number of smaller surrounding hospitals.

American democracy with individual freedom of effort and initiative is the most precious possession of the American citizen. We

should consider well, before we travel too far down side paths advocated by seductive reasoning, as to what the ultimate outcome of any proposal may be. Full employment if realized as fully as possible under private enterprise is highly desirable for all of us, but labor should recognize that full employment attained under a managed economy means in the end the taking over of more and more activities by the state, terminating in government ownership of everything, and for labor, loss of the right to change employers and of the right to strike. Labor will thus find itself back where it started 100 years ago.

Grover Cleveland enunciated the principle that though the people support the Government, the Government should not support the people. This sound principle has temporarily passed into partial eclipse, but it will emerge again as we return to the light of our democracy.

Just as in preceding centuries in other lands, there also have been economic pessimists here with us. In the depression of the 80's, some men firmly believed that as a nation we had reached the zenith of our industrial development, and from there on the government should step in and do something about it. And yet since then under continuing free enterprise we have witnessed the marvelous economic growth and the great increase in standards of living of the past 50 years.

In medicine, there were likewise a few men of limited vision who from decade to decade expressed the opinion that medicine had accomplished all possible, aside from a few refinements of technique. Against this defeatist position we have the miracles of cure of disease in our military and civilian life of the last 20 years.

Because in the evolution of our national life, economic, social, medical, we are faced with new problems which this evolution of progress has *itself* imposed, there is no reason now, any more than in ancient Greece or France or even in Cleveland's time to cry defeat, abandon free enterprise which has always in the past carried us through, and rush to adopt a foreign, myopic, managed economy which has always in the past brought nations to ruin.

To continue to strive for economic improvement, social betterment, and further progress in the distribution of medical care under freedom of initiative, is not a laissez-faire program, but instead is a progressive one. It is the recognition that in medicine adherence to proven principles and, in new fields the development of new technique based on experience, are necessary. Some of

these are:

Voluntary hospital and medical insurance adjusted to local needs and ideologies;

A better distribution of hospitals and medical centers in deficiently supplied regions on the basis of determined need;

The maintenance of standards of medical education so that the coming doctors will have the basic knowledge necessary to apply discoveries and make *new* ones in the cure of disease;

The recognition that poverty and sickness travel together, and the necessity of continuation and improvement in medical care of the medically indigent, under state and local administration, and in a way which will maintain the recipient's self respect;

Extension of the functions of local and state health departments in so far as they can contribute to maintenance of the health of the people;

The continuation of the private practice of medicine and of the patient-physician relationship, free from political intervention;

The recognition that in medicine as in economics, that centralization of power must be limited to that provided by the Constitution, with the preservation of the rights of the states.

The problem of medicine as also of economics and social betterment is the total public good, under a continuation of our American democracy.

Much is thus being accomplished, but the program ahead will demand still further effort in assisting our returning colleagues. In addition it will require clear thinking as to the implications of social and political changes going on about us, lest the coming physicians after years of preparation, find themselves regimented by a socialized and totalitarian system. All mature and thinking physicians are keenly aware of, and desirous of participating actively in all well thought out and workable measures for the improvement of medical care of all the people. They are equally insistent however on the maintenance of our American system of democracy, with freedom of action and opportunity which transcends all other considerations whether of social improvement, of financial advantage, or even of medicine itself.

It is our greatest duty to oppose with all our power those forces which threaten not alone quality of medical care, but our most precious heritage, our American freedom of action, our liberty and democracy in a free society.

THE PRESIDENT'S PAGE

The past should never be forgotten yet we must live in the future and realize that the past is only a guide or steps to greater accomplishments. With the passing of the year of 1945 and all its historic happenings we should look for and meet the responsibility that is ours. The challenge of '46 is waiting and should be met with sound and reasonable decisions and all of us realize that there is no place to stand still. This was thoroughly demonstrated in the thinking of the delegates to the meeting of the American Medical Association with all the committees and it behooves the Oklahoma State Medical Association to think well and wisely before stepping forward. Yet, it is no time to walk if we are to meet our responsibility; we must meet our responsibility on the run.

New Year's resolutions to me mean very little but I do like to think of the verse of a poem written by someone and would like to pass it to the profession as each and every one of us have a definite responsibility to uphold.

"To be so strong that nothing can disturb your peace of mind;

To talk health, happiness and prosperity to every person you meet;

To make all your friends feel that there is something in them.

To look at the sunny side of everything and make your optimism come true.

To think only of the best; to work only for the best and expect only the best.

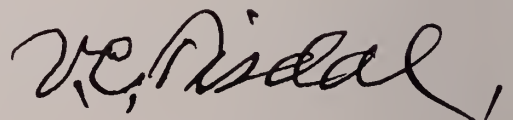
To be just as enthusiastic about the success of others as you are about your own.

To forget the mistakes of the past and press on to greater achievements of the future.

To wear a cheerful countenance at all times and give every living creature you meet a smile.

To give so much time to the improvement of yourself that you have no time to criticize others.

To be too large for worry, too noble for anger, too strong for fear and too happy to permit the presence of trouble."



President.



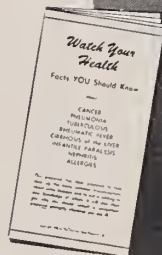
FOURTH IN A SERIES OF CHALLENGES TO MEDICINE'S
Achievements For Tomorrow



POLIOMYELITIS is a dreaded disease. The virus has been isolated and many of its habits are known. But — we must find out why it strikes down some, yet fails to make others sick, and we must discover some method of immunizing susceptible persons against the insidious polio virus.

Until research leads us to the solution, the public should continue to be educated — given the facts about polio so they will not become panicky during an epidemic, but will know how to employ the best preventive measures.

In the pamphlet "Watch Your Health" we have given such information on poliomyelitis—one of the seven serious diseases discussed. Copies for distribution to your patients are available on request.



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The JOURNAL Of The OKLAHOMA STATE MEDICAL ASSOCIATION

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EDITORIALS

THE LOWRY FUND FOR MEDICAL RESEARCH DEDICATED TO TOM AND DICK

The first and the leading independent laboratory devoted to research was the Pasteur Institute. The formation of this well known institution for research hinged upon the creditable work and the popular appeal of a great lovable man. Because of this personal appeal and the hope of forwarding human welfare, one and one-half million francs were raised by subscription in a short time. The beneficent influence of the Pasteur Institute upon the world far outweighs calculable costs in dollars and cents. Humanity is under great obligation to those who made this initial investment in independent research in the year 1886.

Why not pursue the opportunity to honor our own illustrious dead with a memorial which will stand as a perennial blessing to future generations. Why should not the State Medical Association sponsor a plan for such a memorial to be implemented by the Alumni of the Medical School through the University of Oklahoma Alumni Foundation. Why should not the doctors and the people of Oklahoma make this undying contribution as a

part of their rededication, before death robs them of the opportunity.

Dr. Tom Lowry's last appearance at a medical meeting was on Monday evening, December 11, 1945. On this occasion Dr. Cross, President of the University of Oklahoma Discussed Research. Because of his pending program at the Medical School and his keen interest in scientific research for the benefit of humanity, Dr. Lowry was enthusiastic about this logical presentation of a subject which revealed our shortcomings, pointed out our needs and made challenging proposals. In less than twenty-four hours Tom had passed to his reward but not without leaving ample implication of what was uppermost in his mind. It is easy to believe that in his recorded plea for a rededication he was including medical research.

It is a good time to divert some of the wealth of Oklahoma from the well worn channels of conventional industry to the unselfish cause of humanity where the sleepless, critical, spirit of scientific investigation may multiply its values and pass it on to future generations.

Properly conducted medical research requires large resources but even so, exper-

ience shows that the returns in benefits to society are out of all proportion to the costs. Dr. William H. Welch reported that while in Europe in the Eighties he was taunted by a famous professor of physiology because the young men from America, after doing good work in European laboratories, returned to America never to be heard of in the field of research. Dr. Welch said: "I was obliged to explain to him, that the facilities and encouragement for carrying on scientific investigations in the medical institutions of this country are in general very meager, and that one great impetus to such work is almost wholly lacking here, namely, the assurance or even likelihood that good scientific work will pave the way to an academic career. 'When America does wake up to the necessity of these things,' he replied, 'then let Europe look to its laurels.'"

Today Oklahoma stands in relation to many other states as America stood in relation to Europe in the Eighties. In Plato's Protagoras we find that Zeus, fearing for humanity, "sent Hermes to take to men Justice and Shame." Have we not enough shame in Oklahoma to see that justice is done, enough pride to tell other states to look to their laurels. Solomon said: "Mystery is God's glory, but a King's glory is to search out secrets." It should be the glory of Oklahoma to help the scientist search out medical secrets. To those who have idle money we can say the harvest is white. To those who have grown weary of industry with its strife between capital and labor we can offer rich investments where money can work without pickets or strikes, where labor is love, and all sense of time is lost in the hope of achievement. Make this clear and even the miser will throw in his treasure. In the last analysis happiness is a by-product of service and in the end it is truly more blessed to give than to receive.

For the benefit of those who ferociously dispute the possession of wealth we call attention to the lesson presented by the famous painting by George Frederick Watts "Sic Transit Gloria Mundi" which hangs in the Tate Gallery in London. This represents Watts chaste way of saying "You can't take it with you." The man on the bier draped in the gray shroud with the possessions of a successful career about him was of the Epicurean, self-seeking class, leaving nothing to withstand the solvent effects of death. Above the figure on the bier we find this old motto, "What I spent, I had; what I saved, I lost; what I gave, I have."

Man's mundane carer is made up of three great events, birth, life and death. The responsibility of birth is parental, life belongs

to society, death sets the clock for the world's appraisal.

IF PLANS FOR THE LOWRY FUND ARE PERFECTED AND A PLEA IS MADE FOR FUNDS, LET US REMEMBER THE MOTTO AND GIVE WHILE WE CAN.

DOUGH FROM THE MIDDLE WEST IN THE MAW OF MIDDLE EUROPE

Before the section on Gastroenterology at the Southern Medical Association, Ruffin and French discussed "The Nutritional State of the Civilian Population of Southern Germany" and compared the same with other European countries.

The authors reported the nutritional state of children in Germany relatively good but the children in other countries were shockingly emaciated. The adult population in Germany showed great weight loss but other manifestations of food deficiencies were rare. It was estimated that 300 thousand tons of food would be required and that wheat from the United States is the chief need. This means wheat from the middle west.

No doubt the above estimate is entirely too small as there is evidence that General Eisenhower's plans, probably influenced by Morgenthau's book, were based upon about 12 acres of land per family in Germany to provide for 21 million moved people, when, as a matter of fact, it seems that there is only enough available land to support about 7 million over and above the German people already there. If this is true, 14 million of the moved people in Germany alone will starve this winter if outside food is not, in some way, made available. This applies particularly to the areas controlled by the United States and Great Britain. The land is better in the area controlled by the Russians and if they have not removed the livestock and machinery, starvation there should be less imminent.

The size of the world diminishes, while our problems assume larger dimensions.

LET US NOT BE THE FIRST UPON WHOM THE NEW IS TRIED

With apologies we paraphrase Alexander Pope's famous line. From Pope's "Essay on Man," John Marshall and Daniel Webster gathered the principles incorporated in our constitution and expressed in the original purposes of the Supreme Court.

For the past ten years we have relinquished one freedom after another and at last our good citizens are beginning to realize that our vaunted liberties are now fictitious.

Over the ghost of our constitutional rights we hear imperious voices calling us into an obvious form of slavery under the disguise of honey-coated words.

According to newspaper reports our President is advocating compulsory health insurance. Naively the White House indicates that this does not mean socialized medicine and that the patients, doctors and hospitals will remain free. To expect the American people to believe these statements is to imply a high percentage of ignorance. Literate people with a fair vocabulary know that compulsion and freedom are not synonymous. All those who are doubtful should subject the words of politicians to Webster's definitions. Freedom within narrow inflexible limits is slavery, making the individual the absolute property of his master — such freedoms have been granted in all types of slavery with the hope of making serfdom tolerable.

Thomas Jefferson said, "the sum of good government, after restraining men from injuring one another shall leave them otherwise free to regulate their own pursuits of industry and improvement and shall not take from the mouth of labor the bread it has earned."

Benjamin Franklin once said a Nation cannot be "half slaves and half free." Dr. Henry Christian has said medical history must be 100 years old before it can be appraised and properly attested.

No doubt the general historian would accept this standard. Jefferson and Franklin have stood the test of time — why not heed their declarations? Physically the people of the United States have grown taller, broader and stronger and they live longer under medicine as a free enterprise. Will the mind of the public, under the abnormal spur of War and reconversion accept high sounding promises and thereby let the temple of the soul deteriorate under the rule of false gods?

Always it is well to remember that politicians seem to bear the people's misfortunes with Christian fortitude.

DR. TOM LOWRY

The following editorial "We need a Rededication was written by our beloved Tom while the fatal storm was gathering. It was penciled on a small scrap of plain paper while death waited at the bedside. He read it to his wife for approval just before he crossed the shining horizon.

It is impossible for a doctor to read this

clarion call and remain unmoved. Because of Dr. Tom's exemplary life and this last great appeal which comes echoing across the bar, medicine in Oklahoma will be better and the world will be happier.

In the December, 1941 Journal of the Oklahoma State Medical Association there is an editorial about the death of Dr. Dick. These identical twins were born alike, lived alike, looked alike, believed alike, behaved alike, and died alike. In their service to humanity they were in complete accord.

When Dick died, Tom expected to follow, but while he waited no time was wasted. In 1942 when stricken by the anticipated first coronary attack, he calmly said, "I've been looking for you." Thus he met the call of his coronary as St. Francis of Assisi met the cautery—"Brother fire . . . I pray you be courteous with me."

Though he followed his doctor's advice, Dr. Tom's mind was never still. With strict physical limitations he devoted his versatile brain and his genial personality to the interests of the medical school to the welfare of the students, to organized medicine, to public health and to the interests of medical officers returning from Service. The record of his short career as Dean of the Medical School is phenomenal. From his bed in the afternoon he communicated with the State Medical Association office almost daily, always with unfailing optimism and good cheer.

Dr. Tom's activities and accomplishments are well known to every doctor in the state and his death leaves an aching void in the hearts of all who knew him intimately. Not only did he exhibit the humility and fortitude of St. Francis, but he was in possession of all the virtues sought in the great Francis-can supplications:

"Lord, make me an instrument of Thy Peace. Where there is hatred, let me sow love; where there is injury, pardon; where there is doubt, faith; where there is despair, hope; where there is darkness, light; and where there is sickness, joy. O Divine Master, grant that I may not so much seek to be consoled as to console; to be understood as to understand; to be loved as to love; for it is in giving that we receive; it is in pardoning that we are pardoned; and it is in dying that we are born to eternal life."

We need a Rededication

*This is an era of ~~crusades~~ ^{crusades} & ~~organization~~ ^{organization}
~~On these times of questionable peace~~; strikers are
~~the range~~ demanding higher wages, Industry
 protesting its selfish ~~interest~~ ^{interest} civilization ^{is}
 the balance. There is one profession which
 still promotes the betterment of mankind—
 the medical profession;*

*Isn't it time to take an inventory of
 ourselves - ours is a profession of service - ~~yet~~
~~it has been kindly with each of us all the~~
~~if there is~~ ^{there is} profession in the world which is justified
 in crusading for a cause it is the medical
 profession. This crusade should be both
 individual and group organization. ~~The atom~~
~~was not important until it was harnessed & organized. The~~
~~medicine~~ ^{not} ~~has a great future~~ ^{It is rapidly establishing a place in}
~~organized medicine~~ ^{has a great future} ~~we can become leaders~~
 This takes thought, work, and money.
 Let's take an inventory; and rededicate
 ourselves to the profession which has
 meant so much to others & so much to ourselves.*

WE NEED A REDEDICATION

This is an era of organizations and crusades. Strikers are demanding higher wages; industry is protecting its selfish interest; civilization is in the balance. There is one profession which still promotes the betterment of mankind — the medical profession.

Isn't it time to take an inventory of ourselves? Ours is a profession of service. If there is one profession in the world which is justified in crusading for a cause, it is the medical profession. This crusade should be

both individual and group organization. The atom was not important until it was harnessed and organized.

Oklahoma is rapidly establishing its place in medicine through a great educational plan. We can become leaders but this takes thought, work and money.

Let's take an inventory — and rededicate ourselves to the profession which has meant so much to others and so much to ourselves.

Tom Lowry, M.D.

SCHOOL OF MEDICINE, UNIVERSITY OF OKLAHOMA ALUMNI ASSOCIATION

At this holiday season when the doctors of Oklahoma have so much for which to be thankful, a new opportunity is knocking. The doctor who has responded to the Emenhiser-Lamb authorized appeal in behalf of the Alumni Association, has made a good beginning toward the Advancement of Medical Science in Oklahoma. The doctor who has not manifested his interest by sending in the card which accompanied the appeal can plead procrastination as his only excuse. No doctor worthy of the name would be willing to admit indifference. Procrastination is not vicious but it is dangerous. Our human destinies are irrevocably linked with the Medical School. The responsibility rests with the doctors of the state. This is no time to "doubt or hesitate."

Lest you forget — sign the card and send in your check.

IS MEDICAL MANPOWER BEING WASTED

According to military per capita studies, the record show that our soldiers have had more doctors than any other warring nation. While there were some dislocations, some good doctors assigned to non-professional unprofitable and uninteresting jobs, the doctors and other people on the home front were happy in the consciousness that our boys could hardly escape good medical care in case need should arise. But now that the War is over, many are wondering if the return of doctors from military to civil life is being expedited as faithfully as it should be, considering the sacrifices of military service and the long, hard fight made by doctors on the home front.

While this speculation goes on in the minds of medical men in and out of service, The New England Medical Journal of November 1 comes out with an Editorial, "Reluctant Navy" in which the opening paragraph refers to Bill Cunningham's discussion (Boston Herald, October 5) of the Navy's exploitation of the medical profession with utter disregard of the needs of the home front, alleging 30 to 50 per cent more physicians than it has ever been able to use. "The Navy, moreover, even with relative peace brooding over the seven seas, has indicated, according to this same informant, that it did not intend to cut down on the ratio of one medical officer for every 233 men; to support this profligacy it had made the discharge score for doctors 25 per cent higher than the average for other personnel. Since publication of the letter, however, the score has been lowered."

Checking military records, devoid of med-

ical, amounts to a loss of a doctor's time and the dissipation of medical knowledge, but checking privies on a Pacific island is even more unsavory.

From 'somewhere in France' under date of November 9 comes a two page mimeographed document referring to "thousands of rightful gripes by doctors in the service" and stating, "Now that the war is over, these injustices are still present, and it is high time that they be aired, so as to preserve our present standards of medical practice and thus continue to insure the American people the highest degree of health."

Under a three point series of charges they refer to the surplus of doctors in the service and the continued hoarding of same; also the policy of the Army to neglect the induction of young men who have completed medical and dental courses at government expense for replacement purposes. "We find ourselves with no work to do, sitting idly here, simply political prisoners. Is this not a sufficient contradiction to the plea of 'necessity' to arouse in us a suspicion and fear of a sinister plot of the greedy social planners? Do we read socialized medicine in the offing? We are sure we do. We don't like it. We don't want it."

Unfortunately this long complaint bears no name but appears above "A Representative Group of Medical Officers." The question arises — what is the meaning of this unsigned complaint and what are we to think of the references to and finally the threat of socialized medicine. One of these points we quote in order that the reader may cogitate on these questions. "Along the same line, doctors at home, who have never left the States are being discharged with fewer points than many doctors have who are overseas. They are being discharged, and we can't even get home. Again we ask ourselves a question, "Is this justice, or are we making a mistake by expecting justice?"

"The result of these injustices is becoming very evident to us who are witnessing these experiences. The doctor has no work, he is loafing, he is losing his initiative, his desire for and interest in medicine. He is developing a mental attitude which if it continues to be nourished by instances as above, will solidify into a bloc, not only willing to accept, but encouraging socialized medicine. This is not an idle dream, this is now an everyday conversation and admission, spoken no longer with hesitancy, nor with shame, and with less and less regrets. The future is not rosy. It is the desire of the representative leaders of our profession to see as a result of this neglect, an embittered bloc of medical people arise? A bloc so frustrated that the advent of socialized medicine would

be a welcome refuge. We think not, and we hope not. Unless something is done immediately, these grave fears will come to pass.

"In an effort to avoid this we offer the following suggestions:

"1. Let there be adequate medical personnel for American soldiers in each Theatre. No more, no less.

"2. Get the surplus of those overseas home immediately. There is an overwhelming surplus. Get those with long overseas service home now. They can't take much more.

"3. Let the A.S.T.P. and V-12 doctors earn their Government education by a tour of duty overseas thereby allowing the poor, forgotten, disillusioned, lethargic doctor a chance to return home because he is now filled with ennui such that he doesn't know if he is coming or going!

"4. The American Medical Association should pursue its function of protecting the rights of its members. Let us not again see the Journal repeat, without criticism, the exorbitant demands of the Army. It nauseates us who know the true state of affairs, and is an insult to our intelligence.

"5. We think too that after the cessation of hostilities there ought to be at least a degree of medical autonomy. A representative committee of the profession should have the power to decide how many doctors for the Military and how many for the civilian population.

"The future of individualistic American medicine is in the balance. You can tip the scales in the right direction. But it must be done now."

The paradox — if the statements made by this "representative group" are to be accepted as facts then the thoughtful reader must be puzzled about the soundness of their judgment. In other words, if they grow "gripes" under this temporary form of regimented medicine, why, in God's name, would they consider solidifying themselves into an embittered bloc, to encourage "the advent of socialized medicine as a welcome refuge." Why make permanent the "embittering, colaring and slow choking" regimentation and label it a refuge.

Of all people, doctors should manifest wisdom through logical thinking and well considered action.

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ASSOCIATION ACTIVITIES

TRIBUTE TO DR. T. F. RENFROW OF BILLINGS, OKLAHOMA, AT A MEETING OF THE KAY, NOBLE AND GARFIELD COUNTY MEDICAL ASSOCIATION, HELD NOVEMBER 15, 1945 Tom Lowry, M.D.

As a representative of the medical profession, I consider it an honor to pay tribute tonight with you to one of our most worthy members, Dr. T. F. Renfrow. May I add that I feel entirely inadequate in substituting for Dr. Moorman, a rare doctor and a rare scholar.

It is not strange that men should see sublime inspiration in a sacred old church or in a famous painting of Leonardo de Vinci or the sculpture of Michelangelo. It is less strange that we should find sublime inspiration in the life of a good doctor of three score and fourteen years.

Emerson once said — "Young man, be careful of what you want, for you will surely get it." We think that life cannot be so simple as that, yet, experience and observation have taught us that Emerson was right. People usually get what they admire and dwell on.

J. Frank Dobie, a Texas author, who, in 1943, was exchange professor with Cambridge, says in his recent book, "Go out tonight after supper and to a star repeat the old rhyme, 'Star-light, star-bright, first star I've seen tonight, I wish I may, I wish I might have this wish I wish tonight.' If you wish to be a Hollywood star, you will be 'Hollywoodish' if you keep on wishing that way. If you wish to be a millionaire, you will get at least part of it by cutting out everything else. If you wish to be as eloquent as Churchill, you will be eloquent. To know what people admire is to know what people are."

I am sure that Dr. Renfrow, early in his youth, as he looked out from that Missouri farm at the first evening star, wished to be of service to the world, for that wish has for him been fulfilled.

I hope that you will pardon the personal reference. When I was in medical school I sang in a quartet with a young medical student, Tom Boyd. He had a splendid bass voice. He was graduated in medicine, served in the first World War and returned an invalid with tuberculosis. As he lay for twenty years on his sick-bed, he and his brave wife reared and educated two sons and a daughter. I watched with interest and emotion, the growth and development of these fine children. One boy's name was Tom and the other's name was Dick. In 1940, Tom graduated from the University of Oklahoma with the highest honor award which that school could bestow upon a student, that of "best all-around student." Two years later, in 1942, his brother Dick received the same award — "best all-around student." Gentlemen, these accomplishments were not accidents. They were influenced by the inexorable laws of nature. These boys were the grandchildren of Dr. Renfrow, and biologically, Dr. Renfrow's chromosomes dominate their heredity.

In honoring Dr. Renfrow tonight, we are honoring the "doctor of the old school," the "family doctor," the finest institution in American medicine, the men who have given tradition to American medicine, tradition which we love, and that God grant, we shall never lose. I have always thought that it requires more art and more skill to be a successful family doctor than to be a specialist, for the family doctor must be scientist, psychologist, priest and friend. These Dr. Renfrow has been.

His contribution to civilization has been one of being and not possessing, one of duty, not rights and privileges, one of kindness, no greed, one of service and not self. These contributions are culminating tonight in a

tribute which you gentlemen are paying him and which money could never buy. He wears the invisible purple heart, the scars of combat and the unseen awards for service beyond the line of duty. He observes no union hours and has been on the battle line 24 hours a day for 50 years.

Off and on for twenty years, I have been re-reading that masterpiece, "A Doctor of the Old School" from 'Beside the Bonnie Briar Bush' by Ian Maclaren. Each time I read this tribute, such doctors as Dr. Renfrow stand out like mountains in a vanishing landscape.

Dr. Renfrow was a frontiersman. He possessed those vigorous qualities of Abraham Lincoln, William Harrison and Andrew Jackson. They were spurred on by intelligent adventure and fortified with spiritual culture. These were the type of men who sponsored democracy and not only watched the trail of civilization, but blazed the trail. New frontiers of science and the mind are before us tonight. Surely such lives as Dr. Renfrow's shall be guiding stars in our conquering of these frontiers.

Dr. Renfrow, we salute you — we love you, admire you, and respect you for having lived and living a full life, and having been a complete success.

You are an honor to the noble profession of medicine.

OKLAHOMA IN CHICAGO

A Bit of Unofficial Reporting

From Saturday morning, December 1 to Wednesday evening, December 5, 1945, the Oklahoma State Medical Association was being represented in a series of important meetings by a hard working group under the authority of the House of Delegates and the Council of the Oklahoma State Medical Association. In addition, this group had the unofficial council and advice of some of the old guard from Oklahoma who were attending these meetings on their own account, seeking edification and recreation. This is to the credit of the great profession of Oklahoma.

Cooperative Medical Advertising Bureau

The Editor and Executive Secretary attended the special conference of Editors and Secretaries for the purpose of clarifying and improving disturbed relations between the Cooperative Medical Advertising Bureau and the American Medical Association. This is important to Oklahoma because the support of the Journal is largely dependent upon the sale of advertising space to producers of legitimate products. It was obvious that very few, if any, of the medical Journals throughout the United States were in full compliance, thus the need for free discussion and liberalization along certain lines was accentuated.

After several meetings of the C.M.A.B. and two joint meetings of the Board of Trustees of the A.M.A. and the C.M.A.B., certain changes and compromises were effected making it possible for us to go along with reasonable security. At these meetings the influence of Oklahoma was made obvious by the untiring efforts of our Executive Secretary and the savory presence of his quick insight, accompanied by forthright yet conservative action. There will be another meeting in February, 1946 when it is hoped that the present plan may be further evaluated, the future more accurately charted and our Journal economically safeguarded.

Conference of State Presidents

On Sunday afternoon the Oklahoma Delegation attended the first Annual Conference of Presidents and other Officers of State Medical Associations. After routine business was disposed of, the following formal program was presented; THE CHALLENGE—"How Can We

Assure Adequate Health Service for All the People?" by Arthur J. Altmeyer, Washington, D. C.; HOW THE MEDICAL PROFESSION CAN ANSWER TODAY'S CHALLENGE, "Expansion of Voluntary Group Health Care Programs" by Joseph H. Howard, M.D., Bridgeport, Conn.; "Health Legislation Beneficial to the People" by Philip K. Gilman, M.D., San Anselmo, California; "Modern Medical Public Relations" by O. O. Miller, M.D., Louisville, Ky.; "Formation of a National Health Congress" by John F. Hunt, Chicago, Ill.; Round Table Discussion, lead by E. J. McCormick, M.D., Toledo, Ohio.

This was a most stimulating program and deserved much more discussion than the limited time would permit. When at last the round table discussion was announced, the method employed was not conducive to free discussion and the most stimulating feature, namely the address of Mr. Arthur J. Altmeyer of Washington, D. C., Chairman of the Social Security Board, was permitted to pass without discussion since he departed early in order to catch his plane. While the representative of Social Security must have had his eyes opened by the excellent presentation of Howard, Gilman and Miller, it was unfortunate he could not remain for a full discussion of his all-out approval of the principles set forth in the Wagner-Murray-Dingle Bill and the President's proposed program including compulsory health insurance. This representative of a government board, the alleged virtues of which are subject to debate, unwittingly stuck his neck out by dealing freely with medical statistics. Under voluntary restraint the writer sat in wrathful cogitation, longing to tell the speaker of his vulnerable position with only the frail shield of statistics stacked with false conclusions resulting from the layman's limited knowledge of the numerical appraisal of things medical. Sometime, someone should undertake to show lay people the dangers inherent in medical statistics. The doctor lives with the sick and knows how to evaluate the figures, the politician has only the statistics in cold columns, often speaking the language of Ananias.

The ease with which important truths may be successfully buried in statistical shrouds, threatens the present position of modern medicine. The layman knows no better than to build his hope upon false promises. It is the doctor's duty to resurrect the truth and not wait for the crushed facts to rise again.

Mr. Altmeyer referred to the rejection of 38 per cent of the men passing through the induction centers without knowing that only 6 per cent of them were rejected because of medically remediable conditions, without cognizance of hereditary defects, nutritional and neuropsychiatric deficiencies; without calling attention to the fact that most of the disqualifying conditions were in the last analysis dependent upon hereditary influences and environmental defects and ignorance of the fundamental principles of health preservation, all of which the government might well undertake to correct before proposing regimented medicine.

The above conditions might well command government attention and reserve at least partial correction without serious interference of the patient-doctor relationship. The environment created by the ruthless course of modern civilization becomes more exacting and more deadening in its effects upon the nervous system. Though doctors are not responsible they have done much to obviate the dangers particularly in the realm of communicable diseases, thus preserving the domicile for distracted minds awaiting government control of noise, speed and the tragic news and atomic power in order to safeguard the nervous system. Why blame the doctor for the high percentage of psychoneurotic rejections? Government control is the one thing which would immediately check the beneficent evolution of medicine and, in reverse, plunge us headlong toward the dark ages. Bismark did this to Germany. Shall we let the people follow a native born son of that benighted country to the slaughter or shall we rise up and tell them the truth in words which will strike salvation in their souls.

The above discussion should be fairly representative of the honest doctors' mental reflections after Mr. Altmeyer made it clear that the United States Government officials are wholly ignorant of the present status of America. Medicine or deliberately selling a great humanitarian free enterprise down the river as a matter of political expediency. With the hope that the former is true, public education concerning fundamental medical truths should become the primary objective to be pursued "in season and out of season" until our own great philosophers are ready to exclaim with Hippocrates, "We owe a Cock to Aesculapius."

As further evidence of the layman's lack of vision, the gentleman who presented the appeal for the "Formation of a National Health Congress," after praising the medical profession, made the unqualified statement that government is finding it necessary to advocate compulsory health insurance to take care of a need which the medical profession has persistently failed to meet. Looking the members of this Conference in the face, he pointed his accusing finger, saying, "And you have done nothing about it." No one undertook to tell this well meaning gentleman that he, though a young man, had already passed what would have been the average longevity for him if medicine had not taken care of the poor and well-to-do alike during the course of its evolution in this country. Nobody told him that public health, all voluntary health agencies, many foundations for the advancement of the nation's health, and sanitary engineering are founded on the profession's willingness to take care of the health interests of all the people all the time. Nobody told him that many of these agencies are in part or wholly dependent upon the volunteer free or part-pay services of physicians who give freely of their time when they might be pursuing private practice for full pay. Often, without cost to the patient or the tax payer, medicine has been given to the poor

WILLIAM E. EASTLAND, M.D.

F. A. C. R.

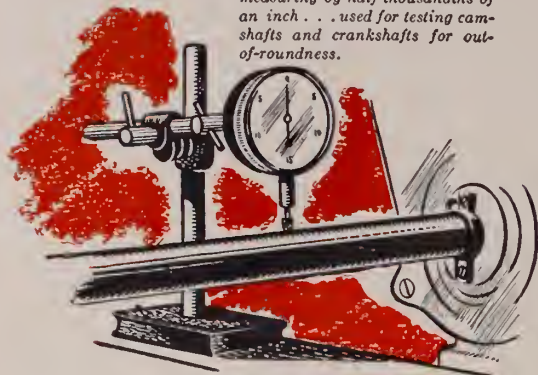
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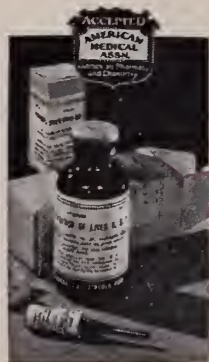
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with so little fanfare that it has passed unheralded and without due credit. The same may be said of the medical support of many of the medical schools where prospective doctors learn how to serve all the people all the time and where they develop the love of mankind and human welfare which, in time of national emergency, constrains them to volunteer their services. If need be, they go to war regardless of their interest at home in order that military personnel may have the best regardless of cost. Is the layman just plain ignorant who says, "you have done nothing." If so, the members of the medical profession are individually at fault for not keeping the public informed. It is time for us to wake up to the fact that the need for so-called "better medical care" is a sickly child of the New Deal. Even though we admit the possibility of political expediency, in the last analysis the father of the child is ignorance and to a great extent the doctors are responsible. In the matter of teaching the public the importance of unfettered medicine in their daily lives, we face the necessity of convincing the doctors that people do not learn through contact alone. They take sanitary protection, personal and household hygiene, good health, increased longevity and the curability of disease for granted. Again we say that they must be taught that all these inestimable benefits are the result of an evolutionary process dependent upon medicine as a free enterprise, representing the restless, critical spirit of scientific investigation and the unhampered application of medical science not by sectional clock hours but all around the twenty-four hour dial as the spirit moved and the occasion demanded. In addition the people should be shown that when medicine is enslaved they will become serfs and the virtues of medical science inherent in the present system will ultimately perish under the annulling influence of regimentation.

Though medicine has been a day-by-day reality in the lives of the American people, they have failed to comprehend its true significance and the price paid in time and tireless endeavor for its present high level of efficiency.

Prepaid Medical Plans

The President's Conference and the House of Delegates of the A.M.A. devoted much time to the various plans for prepaid medical service. This is apparently a defensive mechanism on the part of doctors to meet a need greatly exaggerated by twelve years of New Deal propaganda creating unwarranted alarm and inviting compulsory health insurance and political regimentation of physicians, patients and payrolls. Thus, the President's Conference served as a stimulating forerunner of the A.M.A. House of Delegates. This great organization after brief Presidential addresses immediately devoted its deliberations to the task of representing organized American medicine; meeting the clarion call of advanced medical science; the clamoring demands for liberalization; younger blood in the House and on the Councils; increased democratization and meeting the threat of governmental regimentation.

The most important trends as expressed in the numerous resolutions were the local and national plans for prepaid medical and surgical care; the welfare of returning medical officers, the fight against compulsory health insurance and the need of a comprehensive plan for the education of the public. Also it should be noted that General Hawley appeared before the House and reiterated his plans for reorganization of the medical service in the Veterans Administration providing medical and surgical care approaching civilian standards as nearly as possible and keeping it free from political domination — or else! A bold declaration from a square jaw and a firm chin.

Dr. James Stevenson and Dr. C. R. Rountree, Delegates, were present at every session of the House of Delegates constantly on the alert, registering every transaction with critical appraisal and judicial participation when occasion demanded action. Dr. Rountree served on the Credentials Committee while Dr. Stevenson did a

splendid job of checking and participating in the functions of the Reference Committees.

Oklahoma Delegation Presents Gift To Dr. West

On Monday evening, December 3, there was an open meeting in the Grand Ballroom of the Palmer House for the installation of the President, Dr. Roger I. Lee of Boston. After a short address by the retiring President, Dr. Herman L. Kretschmer and the incoming President, the meeting was devoted to the presentation of the Association medals to the retiring President and the Chairman of the Board of Trustees. Following this the Distinguished Service Medal of the United States Army was conferred upon Dr. Fred W. Rankin. The chief events in this program were interspersed with delightful music adding materially to the dignity and pleasure of the occasion.

On the night of December 4 at the House of Delegates dinner, Oklahoma scored a high mark by the presentation of a large picture of Quanah Parker, Chief of the Comanches, to Dr. Olin West in recognition of his long and honorable service as Secretary of the American Medical Association. The picture was painted by the nationally known Arapaho Indian artist, Carl Sweezy of Arapaho, Oklahoma. The gift was planned and authorized by the Council of the Oklahoma State Medical Association. At an appropriate time following the dinner, Dr. James Stevenson, Senior Delegate from Oklahoma presented the gift which came as a complete surprise to Dr. West. The occasion was climaxed by an impassioned response by Dr. West whose eloquent words fired by his emotion, electrified the audience and led to an exhibition of congratulatory handshaking reminiscent of "Old Time Religion." At any rate, it was good enough for Oklahoma.

A.M.A. President Elected

The following day the House of Delegates rounded out its unfinished business and adjourned after electing the following officers: President, H. H. Shoulders, Nashville; Vice President, William R. Molony, Los Angeles;

three new members of Board of Trustees, John H. Fitzgibbon, James R. Miller and Dwight H. Murray; Secretary, Olin West re-elected; treasurer, Josiah J. Moore re-elected; Council on Medical Education and Hospitals, Herman G. Weiskotten; Council on Scientific Assembly, Henry R. Viets; Judicial Council, Louis A. Buie; Council on Medical Service and Public Relations, Alfred W. Adson, Walter B. Martin and Raymond L. Zech.

Conclusion

This brief, running story of these Chicago meetings is being printed in the Journal for the benefit of those who remained at home. Such meetings convey knowledge and bring about inspiration which should be carried to every corner of the United States. Personal contacts often highlight such meetings. The great clinician and clinical investigator, Robert Herrick, appeared for a series of greetings; the honored General Ireland was surrounded by beves of old friends; Thomas A. Foster of Portland, Maine, with a flair for medical history, through the recognition of a common bond, cornered an Oklahoman to exhibit the bound transactions of the Main State Medical Association for 1877 in which his father alleged that the Massachusetts Society Meeting was inferior in quality as compared to that of Maine. Also that a dental plate of surprising dimensions, swallowed by a patient was recovered and restored to the upper story after several days had elapsed without serious physical or pecuniary results. Dr. Tom Rousing, Secretary of the Canadian Medical Association, brought greetings and invited the members of the American Medical Association to attend the 1946 meeting of the Canadian Association at Banf Springs which will convene only a few days before our meeting in San Francisco in June, 1946. Many other interesting contacts are omitted for want of space.

After such a meeting of the House of Delegates one slips away with a feeling of profound respect and admiration in spite of all the controversial issues.

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ICE AND PUBLIC RELATIONS OF THE
AMERICAN MEDICAL ASSOCIATION
OCTOBER 19-20, 1945**

*Round Table on Legislation—Moderator,
James R. McVay, M.D.*

We highly commend the opening and development of the Washington office. In its first year of operation it has demonstrated its usefulness and the committee recommends its further expansion and that necessary financial support be continued.

We further recommend that each state association be invited to appoint a special national legislative committee consisting of five men composed of the president, secretary and three other members. The function of this committee will be to determine the opinions and wishes of the profession and to keep the Washington office informed of the attitude of the senators and congressmen from their respective states.

*Round Table on the Emic Program—Moderator,
Thomas A. McGoldrick, M.D.*

The Conference unanimously disapproves the present Super EMIC Bill S 1318, and calls on the members of the entire medical profession for personal disapproval:

RESOLUTION:

1. WHEREAS it has been authoritatively and repeatedly announced by the Children's Bureau that the EMIC would be completed six months after termination of the war; and

2. WHEREAS we feel that the objects of this program have been attained, viz. to sustain "the morale of the soldier" and it has been accomplished through the cooperation of the medical profession; and

3. WHEREAS the need of this emergency measure is rapidly diminishing in importance; and

4. WHEREAS there is a definite move to continue this program and provide for its application to the people of the entire United States and with widened scope and expanded power centralized in the Children's Bureau (S 1318, Pepper Bill); and

5. WHEREAS we feel this plan should not have general application throughout the United States because,

- (a) there is no real need for it,
- (b) such compulsory plans are not consistent with good care, excellence of service, nor American principles,
- (c) because the inclusion of children to the age of 21 is not required and their medical needs can be met more efficiently in other ways,
- (d) no health work or medical service that can be rendered by a State or any of its political subdivisions should be administered or controlled by the Federal Government or any Federal Bureau,

NOW, THEREFORE, BE IT RESOLVED:

1. That the present Medical Advisory Committee to the Children's Bureau is not truly representative of the entire Medical Profession. Any program of that Bureau must be administered through the States' Medical Associations, and they should be represented.

2. BE IT FURTHER RESOLVED: That the present advisory and steering committee to the Children's Bureau be abolished and a new committee be established which shall consist of one representative from each State Medical Association to be designated by that Association, and, representatives from such other medical organizations as have a direct interest in the functions of the Children's Bureau.

3. BE IT FURTHER RESOLVED that since the Children's Bureau is not properly related to the Department of Labor, it should be transferred to the Federal Security Agency until such time as all health and medical activities of the Government are segregated into a single department.

4. BE IT FURTHER RESOLVED that the 14-point program of the American Medical Association, and such Resolutions as may be adopted by this Conference, be forwarded through the proper channels to the Children's

Bureau and the Federal Security Agency to bring before them the policies of the profession on the medical economies of Maternal and Child Welfare.

5. BE IT FURTHER RESOLVED that in the distribution of any funds appropriated by the Congress for health and medical services for the use of the separate states, the State Medical Associations be integrated into the control of the expenditure of such funds.

6. BE IT FURTHER RESOLVED that the American Medical Association, through the proper channels, be requested to take action to present the above resolutions to the proper authorities and endeavor to have them put into effect.

It is recommended that every State Medical Association, through the members of its constituent societies, personally place before their representatives in Congress, the defects in the Bill, the harm that would result from its enactment into law, the dangers resulting from compulsory central Government measures, the retardation of our medical progress; also emphasize the medical policies favored and promulgated by these resolutions.

A copy of our recommendation at the general conferences on the Super EMIC Bill S 1318, should be forwarded to every representative in the Congress, to the Secretary of Labor, to the Federal Security Agency, and to every State and County Medical Society.

**Round Table on the Public Relations Job—Moderator,
John H. Fitzgibbon, M.D.**

The section agreed on the importance of establishing two types of public relations separately, one concerned with the members of the medical profession and various medical organizations, the other concerned with the relations of medicine to the public. The committee was agreed that a thorough understanding of public relations by the medical profession is necessary preliminary to the establishment of public relations with the public and urge on the A.M.A. intensified effort toward extending such an understanding through the state and county medical associations. The difficulty of impressing many physicians with the need that they inform themselves concerning correct problems on social medicine and in medical economies lies in the fact that physicians do not read material coming to them through national, state or local medical associations. That is a pretty broad statement.

The proposal has been made that new techniques such as specific, direct by mail education or other medium designed, particularly to elucidate medical economic subjects, constitute a part of an extended program for medical public relations. The committee calls attention to the value of the regional meetings of the Council on Medical Service and Public Relations in the field of public relations for the Council and sections. I have called attention to the following techniques and proposals which were discussed by their sections.

First the Community Health Committee. Insofar as public relations have been immensely benefited by the creation on a community basis of an organization including representations of the medical and allied professions, the social agencies, management, labor, education and the public generally, concerned with promoting an understanding of health problems and a discussion of the various methods by which medical service may be extended and local problems solved. Now that emphasizes what Doctor Kent remarked a few months ago that the medical profession are not the only people concerned with health matters, that the patients in the communities, that the educational groups of school children and health education of school children are of equal importance and equal responsibility. The medical profession should assume that responsibility on a local community basis.

Second, radio. The section heard an extended discussion of the use of radio on a national scale by the dramatization of a work program, the use of prepared records in the form of drama, dialogue, and prepared addresses syndicated through local stations and the use of other radio techniques, among the problems chiefly discussed



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were the securing of free time as compared with paid time on the radio. The use of radio for health education and the use of radio for propaganda on social political problems and the creation of special agencies for utilization of radio such as the efforts now being developed in Michigan. The committee representing the section has no conclusions to offer except to point out that the use of radio for health education and propaganda purposes are still experimental and that within certain limitations medical societies may well test the effects in their own areas of the various techniques as well as others which they may create independently.

In general, the committee feels that the purchase of time by medical societies for health education or for propaganda is questionable particularly since there are definite restrictions on not-for-profit organizations having to do with funds extended for political purposes, preferably medical programs should be educational and non-controversial. Numerous opportunities exist whereby the point of view of medicine may be expressed on well established programs dealing with controversial subjects.

Third, the press. The section heard a discussion of the press relations of the headquarters office of the A.M.A., also statements from various other sections, of the country as to the various ways in which the press is being used to educate the public regarding medical policy. These include a Texas program which involves syndicates of cartoons on articles in the Texas press. A program in Arizona involves the purchase of space for health education and other material and programs in which county societies and commercial medical agencies purchased space for propaganda material. Much is made of the argument that the purchase of some newspaper space creates a kindly attitude on the part of the press toward the medical profession. The committee believes that here also local consideration must govern both the attitude toward procedures and functions to be expected in this manner.

Four. Motion pictures. Already some medical societies are experimenting with the use of motion pictures for health education. Thus far there doesn't seem to have been made available any motion pictures in the social field other than perhaps the March of Time program on medical care. The Michigan State Medical Society suggests such an experimentation in the field of health education. The Walt Disney field has prospects of a considerable number of pictures made with the assistance of federal agencies. In Oklahoma programs are underway for the development of two and three minute trailers on health education subjects to be circulated through all the motion picture houses in the State of Oklahoma. Through the Committee on Visual Education of the A.M.A. measures are now being taken to extend to the medical profession and to the public the motion pictures in the field of health developed by various branches of the armed forces.

Five. Bureau of Exhibits. The Bureau of Exhibits discussed the value of exhibits of various types. The committee felt that local county medical societies should become more familiar with the exhibit material and the facilities available for the extension of exhibits through the headquarters' office and utilize them to the utmost.

In several communities the Variety Clubs have become interested particularly in health as their major project. In Chicago the Variety Club devotes its activities to the support of a sanatorium for rheumatic fever. In Minneapolis the Variety Club proposes to build a building for heart diseases as part of the University of Minnesota Medical School. In Oklahoma the Variety Clubs have established a health center and propose to include, with a division for health education, an exhibit.

A proposal was made from Texas that both the A.M.A. and the individual state medical association engage for liberalization in employment of professional public relations counsel, with a view to utilizing such expert services as consultants for the organization of medical society public relation experiments and in various other ways. The California Medical Association utilizes professional



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public relations in analyzing the public opinion of all foreign medical service and similar procedure was followed in Michigan. In Texas the State Medical Society has retained public relations counsel for advice in the development of its program. Several other states have also recently engaged such services. The committee representing the section on Public Relations urges that the Board of Trustees of the A.M.A. give special consideration to the extent to which such public relations service be utilized by the Association. In understanding the public relations efforts of medicine the committee would call attention to the fact that it is now generally recognized that the relations of the individual physician to the individual patient in the United States are on a substantially sound basis. In other words the public does not express in general resentment against the individual physician. The surveys seem to have shown that the public acceptance of the A.M.A. and its policies is favorable so far as concerns scientific progress, health education and protection of the public against inferior medicine and quackery. Antagonism of the public toward organized medicine seems to rest on the basis that the opponents of organized medicine on the specific program promises complete medical care on what seems to be a relatively small financial outlay whereas, the medical profession has not yet come forward with a specific program for the extension of medical service on a nationwide basis with a system of payment easily available and sufficiently attractive to insure early enrollment of at least 50 per cent of the public. The task of public relations will be rendered much easier if those concerned could be put in possession of a constructive program which they could promote to the public rather than in a position of continuous defense against programs coming from other sources.

Round Table on the Placement of Medical Officers— Moderator, Harold C. Lueth, M.D.

The Bureau of Information of the American Medical Association should be established in a permanent form and maintain adequate records of each physician in the United States from which county and state medical societies could obtain information. The Bureau of Information should also, by the establishment of a cooperative monthly reporting system with state societies, be kept informed of areas needing physicians, and from time to time seek information either directly or through state medical societies to individual physicians concerning location, type of practice, and other relative data.

Each state medical society should be urged to establish an information service. This state information service should collect from various public and private agencies data relating to medical facilities, medical personnel or medical needs and other information concerning medical care within the state. This information service should at all times be in a position to furnish information concerning areas in need of physicians and a complete picture of the medical facilities, physical and economic aspects of any community within the state.

The American Medical Association should be urged to provide advice or service to such state information services relating to methods of organization and procedure and aid the state services in developing a usefulness to the medical profession and to the people of their states.

It is recommended that the American Medical Association request the Procurement and Assignment Service and the Navy, Army, and the Public Health Service to ascertain at the earliest practicable time, the future policy relating to the deferment of medical officers to serve as residents, in order that hospitals may know the extent

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to which they may offer additional opportunities to returning veterans to serve as residents.

It is recommended that the Council on Medical Education and Hospitals be urged to set up at once a method for the more prompt approval of hospitals for residencies and consider the advisability of giving some temporary approval until formal inspections can be made.

It is recommended that all discharged medical officers be given terminal leave pay at the termination of their active duty and prior to the expiration of such accrued leave as they may have, thus enabling them to immediately participate in the benefits provided by Public Law 346 (78th Congress, G. I. Bill of Rights.) Such a procedure will enable the returned medical officer to immediately commence his training in hospitals or medical schools after leaving the armed services.

Round Table on Prepaid Medical Care Plans—Moderator, A. W. Adson, M.D.

Whereas, Medical service plans for prepayment of medical care have been in operation in the United States since 1917 and today, with approximately twenty-two states having plans in operation or about to be placed in operation, only about eight million out of a total population of one hundred thirty-six million American people are subscribers to these plans, or only about six per cent of the total population; and

Whereas, We hope to eliminate forever the dangers of federal control of medical practice, efforts must be made to have a larger proportion of the working classes of this country insured under prepayment care plans and this seems at the present time to be possible only through a nationwide plan operative in all the states. Now, therefore,

BE IT RESOLVED: That this Committee recognizes the great importance of definite action by the profession at this time with respect to prepayment for medical service; This being true, it is the recommendation of this Committee that each of the forty-eight states be given an opportunity to enter in the discussion of this vital problem. Therefore it is recommended that a meeting be called for November 30 and December 1, 1945 in Chicago, with two representatives from the medical society of each state to go thoroughly into this matter; the findings of this group to be incorporated in a resolution to be presented to the House of Delegates of the American Medical Association with a request for its approval at its meeting on December 3 to 6, 1945, and that this Committee recommends:

First, that Dr. A. W. Adson of Rochester, Minnesota, act as chairman and call the proposed meeting on November 30 and December 1.

Second, that the delegates to the proposed meeting consider the formation of a nucleus for the development of a program for medical service on a national basis, in correlation with the various states which now have plans in operation, and to assist those states which do not at present have medical service plans.

Third, that a Committee be appointed at this session to prepare the agenda for the proposed meeting on November 30 and December 1, 1945.

Round Table on Rural Health Problems—Moderator, F. S. Crockett, M.D.

Mr. Chairman I have no resolutions at this time. I want to express the gratitude of the moderator of that section and those attending the Round Table in the afternoon. The work on rural medical service is so

new, that we have no fixed opinions about what must be done or what the needs are. It is in a definite mental stage and we would invite the cooperation of all the states to have a more active interest in the problem which I am quite sure presents one of the musts of our profession if we are to keep with us a sound conservative people who believe very much as we do in the voluntary way as contrasted with the compulsion which has been threatening us.

Round Table on Activating the Fourteen Point Program—Moderator, Louis H. Bauer, M.D.

1. The implementing of this first point must be by education of the public. There are constant attempt to overthrow the whole order of medical practice on the theory that the people in this low economic group have inadequate medical care, whereas, the solution is in raising the economic level of these people.

We recommend constant publicity on the facts of this particular problem through the American Medical Association, the state associations, the county societies, and the women's auxiliaries, by addresses and articles not only in the medical journals but also in the lay press.

2. The implementing of this second point is by means of legislation. Such legislation should also be of interest to the A. P. H. A., the State and Territorial Health Officers Association, and the U. S. P. H. S. We recommend that the A.M.A. sponsor a conference with these groups in an endeavor to enlist their cooperation in legislative efforts to accomplish the purpose of this item.

Since a special round table will report on this subject in detail, we recommend that any resolutions adopted by the conference on this subject be integrated into the implementation of these three points of the program.

In addition we recommend that the medical care of Veterans be integrated into these voluntary plans of hospitalization and medical care. This large group would help stabilize these plans and at the same time give the Veterans free choice of physician and permit them to be cared for on a local basis without the necessity of vast extensions of government institutions.

6. These surveys should include every medical facility, not just certain ones as no true picture can be obtained of any facility without considering the problem as a whole and with due reference to every factor.

These surveys should be made by state agencies, public and private with cooperation and approval of the state medical associations.

7. This likewise is a legislative matter and should be implemented by the A.M.A. again in collaboration with the other agencies listed under item 2, together with the collaboration of the state medical associations.

8. This is again a purely educational matter and the implementation should be through the A.M.A., the state associations, the county societies, the women's auxiliary, and the appropriate voluntary health agencies. The bulk of the information necessary is, of course, local, and hence the educational activities must be necessarily largely local.

9. This, of course, ties in with item 6, and the same agencies should keep the surveys up to date.

To implement these items we recommend that the A.M.A. continue its close contact with the Army and Navy and that it continue urging that physicians be released as rapidly as possible, and further that the existence and functions of the Bureau of Information be steadily advertised to the men in the services.

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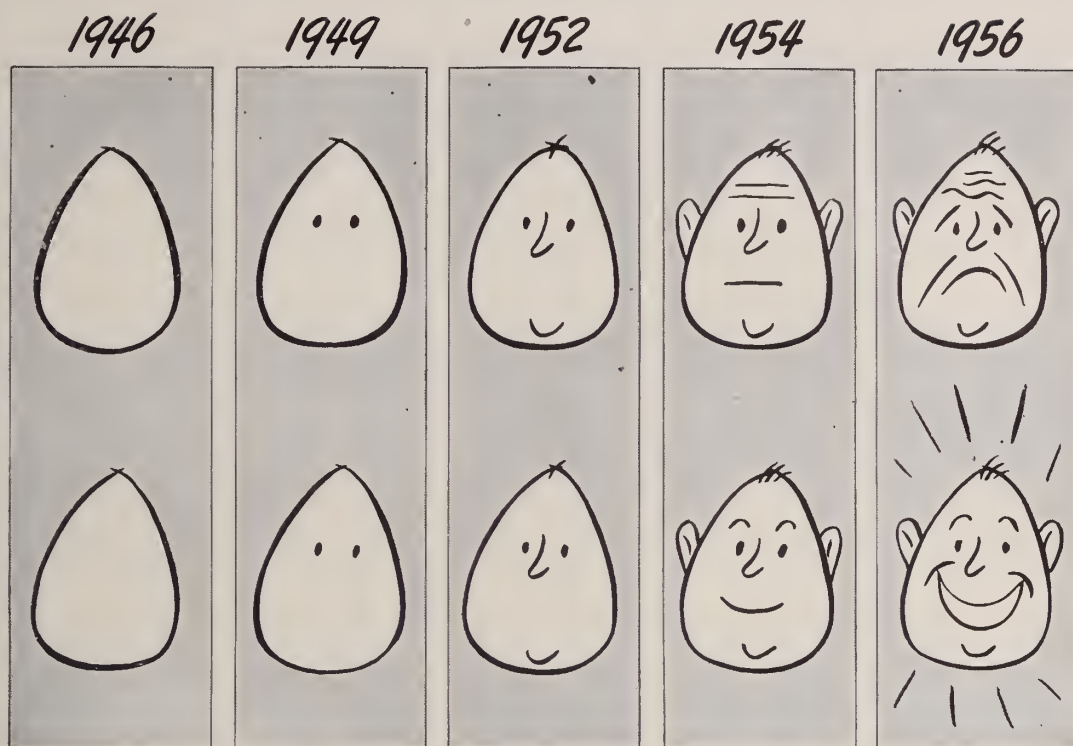
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We also recommend that pressure be continued on the responsible authorities by both the A.M.A. and the state medical associations to effect the recommended changes in the draft regulations, and that if this fails legislation be sponsored to bring about these changes.

With reference to item 11, we feel that this is in part related to the establishment of adequate diagnostic facilities so that there will be attractions for the physician in rural areas. While the training of more physicians is necessary, this is no surety that when trained they will settle in rural areas. The use of grants from the various funds or subsidies by the local communities will in some cases be necessary, in addition to the setting up of proper diagnostic facilities, if the problem is to be solved. The surveys recommended in items 8 and 9 should include the needs of rural areas as to additional physicians and investigation should be made of the most feasible method of alleviating the shortages.

12. We feel that the wording of this item is already somewhat obsolete as there are no longer 60,000 physicians nor 12,000,000 persons in the services. The number is dropping steadily. The purpose of this item originally, however, was to protect the rights of all Americans to express themselves on any revolutionary change affecting their daily lives.

We recommend that the American Medical Association give notice, that it has not only in the past, does now, but will in the future oppose any legislation which by its very nature engenders a poor type of medical care, encourages dependency, or regiments either the patient or the physician.

We consider such legislation as compulsory sickness insurance, no matter how it may be dressed up, as reactionary. There have been attempts for over thirty years to bring about compulsory sickness insurance in some parts of this country and for several years nationally. All the bills introduced have the same basic faults. It is the same old spectre, with the addition of occasional new cosmetics, in the hope that they will fool the public into thinking it is something new. It is an all or nothing program and is in the nature of a "shotgun prescription."

On the other hand, we feel that our program attacks the basic deficiencies, offers specific treatment for specific ills, is elastic and can be modified from time to time as conditions indicate.

We feel that the program should be rearranged in its order so that it may be divided into four general aims.

1. Those primarily educational. This covers items 1 and 5 namely the removal of economic barriers so that a great deal of medical care will be unnecessary by eliminating its need; and extension of information to the people on services available.

In our educational program we particularly urge that state associations do their utmost to reactivate and revive the county societies. The vast majority of these are poorly attended and the members are indifferent to the problems that beset us. No education of the public can be successful unless the profession also is fully educated.

2. Those primarily calling for positive legislation, or administrative action by governmental agencies. This includes items 2, 6, 7, 9, 10, 11, 13, and 14; namely, extension of public health services for the prevention of disease; surveys to determine our needs, with these surveys continuous so that our remedies may keep pace with our necessities; the setting up of proper diagnostic facilities where lacking; federal aid where local communities cannot finance their necessary activities, but the activities to remain under local control; the readjustments in personnel requirements of the services; the necessary relocation of physicians; and necessary changes in the draft regulations.

3. Those calling for positive action but not as a rule legislative action. This includes items 3, 4, and 5; namely, extension of hospital and medical insurance on a voluntary basis, already of proven value, to cover the country; and the use of this principle in caring for the indigent.

4. The one item calling for negative action, namely item 12. This refers to the Wagner-Murray-Dingell bill and other types of vicious legislation.

Finally, we recommend, that just as we have in our program recommended continuous surveys of our medical facilities so that they may be kept up to the best possible level, the Board of Trustees and the Council on Medical Service and Public Relations continually survey the constructive program for medical care and likewise keep it constantly up to date so that it will stay at least even with, and, if possible, a step ahead of the needs of the public.

**MEDICAL CARE FOR VETERANS, PAUL R. HAWLEY,
MAJOR GENERAL, MEDICAL DIRECTOR, VETERAN'S
ADMINISTRATION, PUBLIC RELATIONS CONFER-
ENCE, COUNCIL ON MEDICAL SERVICE AND
PUBLIC RELATIONS, OCTOBER 19-20, 1945**

I am going to present to you very briefly and very frankly what we have in mind to improve the medical service of the Veterans' Administration.

It falls into two large problems, one of institutional care of the sick and injured veteran and the other is out-patient care. I presume the large bulk of the membership of the component societies here is interested more in out-patient care than in institutional care and I shall devote most of my time to explain what we intend and hope to do in that. First I should say that we have started institutional care. We are trying to get the best people in the United States to help us to put our program into operation. We are going to the medical profession, to people known and respected in the profession for that help, to improve our institutional care by getting attending staffs from the community, from schools near our hospitals.

We are most fortunate in having a man come with us whom you all know, and whom you all respect. I just want to tell you that Dr. Paul Magnuson of Chicago is giving up his practice and for a mere pittance is coming full time in our office in Washington to organize the institutional care of the veteran. Dr. Paul Magnuson is here, and I wish to introduce him.

Now we have people like this who make such sacrifices in the interest not only of the veteran, but in the interest of the medical profession. I think we are going to succeed if we are not stimulated by personal local interests commonly known as politics. The people, on the whole, I think, have been educated rather badly in the care of the veteran, and I sometimes feel that the pressure is brought upon us to build veterans' hospitals much the same as it is to build post offices. That has got to be discouraged. We can only put veterans' hospitals where we can give high-class medical assistance on part-time basis from the outside.

Now let us get to the problem. I think you are most interested in this one than institutional care, which is the out-patient problem. At the moment all women veterans are entitled to out-patient care at whatever expense for any disability, service-connected or not service-connected. Men veterans are entitled to out-patient care only for service-connected disability. This introduces an administrative problem in the determination as to whether or not a man going for outpatient care is entitled to it at government expense. However, that is not an insurmountable problem and can be solved in many ways. It can be solved by the ordinary identification card which can be issued to each veteran, and without proclaiming publicly, a code number of disabilities can be used and he can display the card when he comes in. It will show the disability if service-connected and the doctor can look after him with some assurance on his pay.

We don't want to have the veteran treated in any way as a class apart from society. He is a part of society and insofar as possible he should get his medical care just as any other member of society in the United States gets his medical care. In the past it has been customary to designate one, usually, or two physicians in the community, as Veterans' Administration physicians. All veterans are forced to go to them. Now there

are many exceptions to this rule but in many places the men who either have been recommended by the local society for this position, or who have accepted the position, are men who have plenty of time on their hands and to whom not many other people in the community are going. We should like to reverse that. We should like to have every physician in each community designated as a veterans' physician and we should like insofar as possible for the veteran to choose his own physician in his own community like any other person in the community does.

How are we going to work that out? I don't know how many counties there are in the United States, three thousand or something. The problem may have to be worked out in three thousand different ways. Each county has its own problems—has its own medical problems—and we are not interested in demanding but one plan. We will subscribe to three thousand different plans. We will make the shoe fit the foot of the county society.

I want to tell you of our start and we have made a start. The Monmouth County New Jersey Medical Society last May, submitted a plan whereby, as a county society, they would give out-patient care to the veteran. They would establish an out-patient clinic. The clinic would be staffed with various specialists one night a week, or two nights a week, but would be kept open all the time with somebody in attendance for the veteran to come to in an emergency. They would have regular meetings of a rather special staff. They would make the contact with the local regional officers of the Veterans' Administration and would establish the service connection. In cases that are not service-connected these people say, "Well they are a responsibility of the community. If the government pays for them we are no worse off than any person who walks into the office. We send them a bill and if they pay we get paid." It is the same proposition as any patient who walks into a doctor's office. They have arranged with all the hospitals in the country to furnish the physical arrangement for the out-patient service, the necessary space, and the equipment for the out-patient service, the necessary space, and the equipment. The fees to be paid are a subject to be discussed between us, and I shall take up fees in a minute. For some curious reason this proposal of last May was turned down, and shortly after I went with the Veterans' Administration, about six weeks ago, I heard about it. I immediately telephoned the president of the society and asked if their enthusiasm had been damped, if they were willing to reopen the subject. Fortunately for the Veterans' Administration they were. They came down to Washington and laid out the plan. There were a few things which under the law we couldn't do but which we adjusted to the satisfaction of both sides.

There was one part of their proposal I thought was extremely unfair to them and that was they were going to operate this thing three months without any expense to the government except the fees paid to the physician. No expense to the government for clerical help, etc. They wanted to make a trial run, establish how much it was going to cost, how much the government ought to pay. They insisted upon the trial run being made at their own expense which was a most generous offer and that they insisted upon.

Now as to fees. We could no more set a scale of fees in Washington which would be applicable to every community in the United States than we could set a scale of prices for meals to be applicable in every restaurant in the United States and we don't intend to do it. We don't intend to publish our scale of fees. We told the Monmouth County, "You put in a scale of fees you think is fair and equitable to your own people, remembering only one thing—there are many times when

a doctor does charge a fee but does not get it. The Government wants to pay as much as is reasonably justified. We don't want to beat the doctor down at all. At the same time we don't think we are in a sound position if we pay the top prices he gets from his wealthiest patients, but you submit us a scale of fees for Monmouth County and we are not going to have much argument about it."

That is for Monmouth County. If we go into metropolitan New York we pay a different scale of fees. Obviously the scale of fees varies with communities and we are going to have no set scale.

The next thing that frightens many people about having anything to do with the Veterans' Administration is the terrific amount of administrative work the doctor has to do. What he does for the patient is the least of his work. He has interminable forms to fill out. In the first place we are going to try to simplify these forms. You must remember that there are pensionable cases, and the government does have to have some permanent record of what is wrong with a man. That does not have to be as voluminous as it is now, but we do have to have a record. Furthermore, anybody who draws pay from the government has to sign something once a month, or every time he submits a fee, somebody has to fill out a form. Our position is that since the Veterans' Administration requires all this over and above medical care, the Veterans' Administration should furnish the clerical help to do it. And if we establish an out-patient clinic in any town we shall put clerical help in there to fill out the doctor's vouchers for his charges. They will also be available to write up the medical history of the case from his notes on the case, taking away from the doctor any necessity for doing all of this administrative work.


We have only made a start in one county. We hope that the news gets around to other counties because it is essentially a local arrangement. Conditions vary so widely in different parts of the country. We will submit a plan to the thirteen districts when we decentralize. The local regional man will be given authority to deal with local societies, to advise them as to what kind of a plan will meet the requirements of the law and we will get them approved as rapidly as possible, and we would like to see them in operation.

In conclusion I want to say that in the interest of the veteran, and the interest of the people of the country, we want this care of the veteran to be done by a free and unregulated profession. We want to preserve the structure of medicine in this country. We want the minimum of government supervision of the care of the veteran. We are willing to rely on the large picture for the honest effort of the profession as a profession and we feel—and perhaps it is apropos here with the discussion which is before you in the nature of Public Relations—that we are contributing something to the medical profession in giving them an opportunity at no great sacrifice.

The Celestial Surgeon


If I have faltered more or less
In my great task of happiness
If I have moved among my race
And shown no shining morning face;
If beams from happy human eyes
Have moved me not; if morning skies,
Books and my food, and summer rain
Knocked on my sullen heart in vain;—
Lord, Thy most pointed pleasure take
And stab my spirit broad awake.

Robert Louis Stevenson.



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Jefferson and Franklin on Mesmerism

Pjysegur, a disciple of Mesmer, that same summer made valuable discoveries in hypnotism, regarded as a form of magnetic sleep, and used by him if not to much therapeutic purpose at least without the uproar of Mesmer and Deslon. But all of them came under the same condemnation, and hypnotism went undeveloped for half a century. The mesmerists had been so much involved in alchemistic doctrines, extravagant claims, and mountebank ceremonies that the steps they had taken toward mental healing by suggestion were overlooked. The royal commission overlooked them. Its report was taken for the complete exposure of an absolute delusion, what Jefferson called a "compound of fraud and folly." Mesmerism ceased to be a fashion. Mesmer left Paris. Animal magnetism sank again to its earlier level among popular superstitious. Franklin, more widely known than any of his colleagues, was supposed throughout Europe and America to have been their chief in this deathblow to quacks.—*Benjamin Franklin by Carl Van Doren*, pp. 716-717. *The Viking Press. New York. 1938.*

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Legal Opinions

STATE OF OKLAHOMA
Office of the Attorney General
Oklahoma City
November 18, 1945

Dr. James Osborn, M.D., Secretary
State Board of Medical Examiners
Frederick, Oklahoma
Dear Sir:

The Attorney General acknowledges receipt of your letter dated November 9, 1944, wherein you, in effect, ask if it would be a violation of the medical practice act of this State for a radiologist who is not licensed to practice medicine and surgery in Oklahoma to, for a fee or compensation, read radiographs for a licensed physician and surgeon of this State and give him "advice in regard to treatment" of the patient so radiographed.

In reply you are advised that 50 O. S. 1941 § 491, makes it a misdemeanor for a person to practice medicine and/or surgery in the State for a fee or compensation without having the legal possession of an unrevoked license to so practice. Section 492 *idem*, which defines the practice of medicine and surgery in this State, is in part as follows:

"Every person shall be regarded as practicing medicine within the meaning and provisions of this Act, who shall append to his name the letters 'M.D.', 'Doctor', 'Professor', 'Specialist', 'Physician', or any other title,

letters or designation which represent that such person is a physician, or who shall for a fee or compensation treat disease, injury or deformity of persons by any drugs, surgery, manual or mechanical treatment whatsoever."

In 48 Corpus Juris, page 1079, Section 31, the following general rule is set forth:

"Where a person without a license or certificate performs acts constituting the practice of dentistry, medicine, or surgery, he is not relieved from liability therefor by the fact that he performs the acts as an assistant to, or under the direction and supervision of, a duly authorized practitioner, ***"

The above quoted general rule clearly states that if an act on the part of a person who is not licensed to practice medicine and surgery constitutes the practice of medicine or surgery as defined by the applicable statute, the mere fact that it is performed under the direction or supervision of a licensed physician and surgeon is immaterial. It will be here noted that if the rule were otherwise a layman could, for a fee or compensation, lawfully perform a major surgical operation under the direction or supervision of a licensed physician or surgeon. The conclusion above reached is supported by the case of *Gobin, et al. v. State*, 9 Okla. Cr. 201. 131 Pac. 546, wherein the Criminal Court of Appeals of this State held in the second and third paragraphs of the syllabus as follows:

"A person who does not possess a valid unrevoked certificate from the state board of medical examiners is not entitled to practice medicine under the laws of this state, except in emergencies and such other cases as are specifically exempted by the statute. *And this is true even though he worked with or under the directions of a duly authorized practitioner*; and it is immaterial whether he works for a fee, percentage, or on a salary.

"(a) A physician who is authorized under the laws of this state to practice medicine has no more right to aid one who is not properly authorized to evade the law than such unauthorized person has to act on his own responsibility.***"

The term "radiology" and "radiologist" are respectively defined in Gould's Medical Dictionary as follows:

Radiology . . . "The science of radiant energy."

Radiologist . . . "Proposed term for a person versed in radiology, and who may, in addition, be skilled in applying the science."

Therefore, if the radiologist mentioned by you actually treats "disease, injury or deformity of persons" for "a fee, percentage, or on a salary" by the use of "radiant energy," he will be guilty of violating the provisions of 50 O. S. 1941 § 491 and 492, *supra*, and this would be true whether or not he is doing so under the direction or supervision of a licensed physician and surgeon. Moreover, if any such physician and surgeon aids, and abets said radiologist in so practicing, he also, will be guilty of violating said sections.

The Attorney General is of the opinion, however, that if the radiologist mentioned by you limits his activities to the reading of radiographs for a licensed physician and surgeon of this State and to the giving to him of "advice in regard to treatment" of the patient so radiographed, which advice said physicians or surgeons may accept or reject as he sees fit, neither said radiologist nor said physician and surgeon will be guilty of violating sections 491 and 491.

The principles of law announced in this opinion are in harmony with those announced in the opinion of this office to you dated May 11, 1942, the original of which is in your office.

Very respectfully,
Randall S. Cobb,
Attorney General of Oklahoma.
By Fred Hansen
First Assistant Attorney General.

FH:LW
Approved in Conference
11 Mo. 15 Day, 1944.
A.M.

Obituaries

Tom Lowry, M.D. 1891-1945

In writing an obituary of Dr. Tom Lowry, it will be unnecessary to try to speak in laudatory terms to those who knew him. He was exceptionally naive in making friends and keeping them. He was a man among men. Respected because of his ability in his chosen profession, respected because of his sterling qualities as a man, whom no one could say ought but good, both as to his irreproachable character, friendly manner and religious background. Endowed with a beautiful voice, he and his brother responded generously in singing alone or with a quartet. Strong of muscle and fleet of foot, these brothers were known for their prowess in athletics. In fact their versatility was remarkable.

In speaking of Dr. Tom, it would be amiss not to speak also of his identical twin brother, Dr. Dick, who succumbed in the same dramatic way four years ago. Two brothers could not have been more alike in stature, looks and accomplishment than these two. How Tom carried on no one knows, as he knew what fate had in store for him when his father, his older brother and his twin brother had been victims of coronary occlusions. He often spoke of his impending doom, but his fortitude and equanimity was marvelous. With this in mind he gave up a large and lucrative practice after his brother's death, and was chosen Dean of the University of Oklahoma Medical School, at which time he was then occupying the Chair of Clinical Medicine. The morning after his election he was stricken with a coronary episode which laid him up for several months, and thereafter only a few hours a day was given to this office as Dean.

Having lived in Oklahoma most of his life, he graduated from Oklahoma University at Norman with a B. S. in 1914; and then in 1916 an M. D. Having acted as councilor for his district in the State Medical Association, the horizon of his activities was broad, which enabled him to be of great value to the betterment of medicine. He served as a Captain in World War No. 1 and was with the 24th Evacuation Hospital in France, after which time he took a course in the Colorado School of Tuberculosis in 1924. After his internship in New York Polyclinic hospital and City Hospital a year each, he was married to Miss Ethel Maude Smith of Guthrie, Oklahoma.

He was a member of the County, State and American Medical Associations; the American College of Physicians; Certified by the American Board of Internal Medicine; member of the Methodist Church; Rotarian; Phi Beta Pi Medical fraternity; Phi Beta Kappa national scholastic fraternity; Phi Mu Alpha biology group; Pe-et because of being the outstanding freshman in

the University, and the Letzeiser medal as an outstanding senior.

Dr. Tom was stricken with the second coronary episode after a night call to his aged mother, and died the same day, December 11. His remains were interred in Memorial Park Cemetery.

He is survived by his mother, Mrs. Eva Lowry; his wife, Mrs. Ethel Maude Lowry; three daughters, Mrs. Robert Wallace King of New York City, Miss Jean Lowry, a student in Columbia University, and Miss Elizabeth Ann Lowry, University of Oklahoma; one granddaughter, Sheryl Lou King, New York City.—L.A.R.

P. B. Gardner, M.D. 1889-1945

Dr. P. B. Gardner, prominent Guthrie physician, died in a local hospital Monday, November 24, 1945. Stricken nine days previously with an illness which necessitated two major operations in less than one week, his condition was complicated by an overtaxed heart.

Dr. Gardner was born in 1889 at Melbourne, Arkansas. He was graduated from the University of Arkansas at Fayetteville, and took his Medical degrees at Tulane University. He began practice in 1915 at the Rockefeller Foundation in the West Indies, where he served for five years. He came to Marshall in 1925, where he practiced until moving to Guthrie in 1937, when he became associated with Dr. Louis Ritzhaupt.

Dr. Gardner had made a large place for himself in that community in professional, civic and social circles. He was serving his second term as member of the City Council, and was a member of the First Methodist Church, Chamber of Commerce, Lions Club, the medical fraternity, Chi Zeta Chi, and was a 32nd degree Mason. He was also a member of the Logan County Medical

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Society, the Oklahoma State Medical Association, and the American Medical Association.

Survivors include his wife, two sons, one daughter, two grandchildren, one brother and four sisters.

**William Birnbaum, M.D.
1905-1945**

Dr. William Birnbaum, 39, prominent Tulsa physician, died on November 9, 1945, in a hospital in Springfield, Missouri, of injuries suffered in an automobile accident 30 miles east of there. Dr. Birnbaum was reported to have lost control of his car on a curve on a hill. He was enroute to Rochester, Minnesota, where he was to take post-graduate work at the Mayo Clinic.

Dr. Birnbaum was born in Pervomoysk, Russia on December 8, 1905. He was graduated from the University of Minnesota School of Medicine in 1939, and interned at Morningside Hospital in Tulsa; since which time he has been associated with the Tulsa Clinic. He was a member of the Tulsa County Medical Society, the Oklahoma State Medical Association and the American Medical Association.

Funeral services were in Kansas City, where his parents, Mr. and Mrs. Sam Birnbaum, reside.

Mrs. Fred S. Clinton

Mrs. Jane Heard Clinton, wife of a pioneer Tulsa County physician, died in a Tulsa hospital on November 8, after an illness of several months. Mrs. Clinton was 70 years old at her death. She was the daughter of James Lawrence Heard and Melissa Harper Heard of Elberton, Georgia. She and Dr. Clinton were married in April, 1897, and established their home in Tulsa County the following year. Dr. and Mrs. Clinton entered into the activities of the small somewhat wild western town of Tulsa with enthusiasm, making many friends and taking the lead in Tulsa's civic and cultural organizations. Mrs. Clinton was a charter member and life time president of the Hyehka Club, pioneer music club of Tulsa. She was a charter member of the Auxiliary to the Tulsa County Medical Society and was an honorary member at the time of her death. Mrs. Clinton had been a member and past officer of the Tulsa Chapter of the Daughters of the American Revolution. She was active in many other cultural and civic organizations. For many years she had been an active worker in the Boston Avenue Methodist Church. The Auxiliary to the Tulsa County Medical Society voted the following Resolution as a tribute to Mrs. Clinton:

WHEREAS it has pleased our Heavenly Father to remove from us by death our beloved member Jane Heard Clinton:

BE IT RESOLVED that we put on record our appreciation of her fine qualities of mind, character and devotion to our Auxiliary. She was a woman richly endowed with kindness. To know her was to love her. Her Christian spirit was an influence for good throughout her life. Her advice and counsel were always sound and based upon the principles of Christianity, which guided her actions all of her life; her understanding and appreciation of her fellowmen, her loyalty to city and country, to her home and husband, will live in the hearts she has left behind, to never die.

BE IT FURTHER RESOLVED that a copy of these Resolutions be sent to her husband, a copy to the State

Medical Journal of Oklahoma and a copy be placed in the minutes of the Secretary's book of the Auxiliary to the Tulsa County Medical Society.

Respectfully submitted,

Mrs. Frank L. Flack; Mrs. Eric M. White; Committee on Resolutions.

REPORT OF COMMITTEE ON MATERNITY AND INFANCY

It was brought to the attention of the committee that approximately 30 per cent of the Birth Certificates filed at the State Health Department fail to contain insertions of serological blood tests for syphilis. This problem was discussed in a joint committee meeting with the Committee on Venereal Disease and a joint report was made.

The committee, in discussing the scope of the varied problems in relation to infancy and pre-natal care, makes the recommendation that the Committee on Maternity and Infancy be divided and two committees be appointed, one to continue the study on problems in relation to the field of obstetrics, and the other committee to devote its time to the problems of pediatrics.

The committee recommends to the society that request be made to the State Health Department that on all serological determinations for syphilis of pregnant women and RH determination and blood typing should be made, and attendant physicians doing obstetrics containing information in relation to the RH factor. The Committee, in cooperation with the State Health Department, is circulating to all physicians reprints in relation to the treatment of eclampsia.

The committee is continuing its study on maternal deaths in cooperation with the State Health Department. The Committee, in a joint meeting with the committee on Venereal Disease, recommends an information circular be sent to all practitioners advising that a pre-natal serological test for syphilis be made, and it also should be pointed out that this is a statutory provision and, in addition, that it is mandatory that a notation of this test be made on birth certificates that are filed with the State Health Department.

Signed: Catherine T. Brydia, M.D., Chm.,
En N. Smith, M.D.
Carroll M. Pounders, M.D.
O. C. Armstrong, M.D.
J. T. Bell, M.D.

Grim Irony

There is grim irony in writing about progress in medicine at a moment when thousands of people are being slaughtered daily on battlefields. Generations of physicians, in an endless number of hospitals and laboratories, have endeavored to solve some of the manifold problems of health and disease, of life and death. They have thought and laboured and struggled in order to prolong human life and to make it healthier and happier. And then a war breaks out. All efforts are destroyed and it becomes the physician's task to treat man-made wounds and diseases caused by human action.—*Progress in Medicine*. Iago Galdston, M.D., with a foreword by Henry E. Sigerist, M.D., p. vii. Alfred A. Knopf. New York. 1940.

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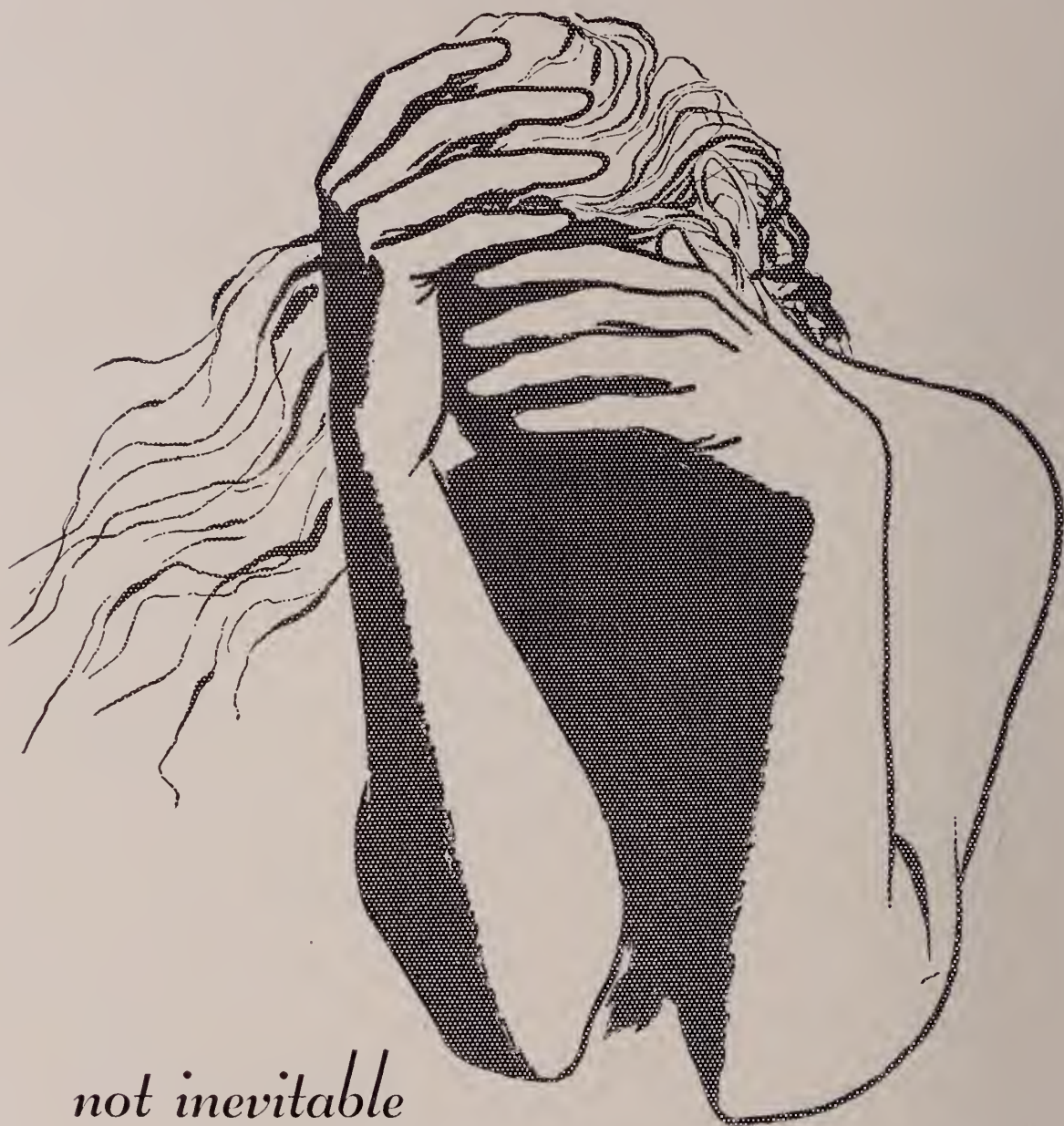
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O. U. ALUMNI ORGANIZES FOR FUND DRIVE

State Building Program to be Augmented by Research Endowment Fund

The Alumni Association of the School of Medicine of the University of Oklahoma met at breakfast at the Biltmore Hotel, November 27, 1945, during the Oklahoma City Clinical Society meeting for the election of officers for the coming year and for extensive discussion of the procurement of endowments and grants for the School of Medicine of the University of Oklahoma. Present at the meeting, which was well attended, were Dr. George L. Cross, President of the University of Oklahoma; Mr. Rosecoe Cate, Assistant to President Cross; and Mr. Ted Beaird, Executive Secretary, University of Oklahoma Alumni Association. These three guests explained the functioning of the University of Oklahoma Foundation at Norman, which is the organization that accepts grants and endowments from wealthy citizens for the University of Oklahoma. They explained that any sum of money could be given by a donor through this foundation for the medical school if the donor specifically requested that his gift be given to the medical school.

The Alumni Association of the School of Medicine of the University of Oklahoma will work with the University of Oklahoma Alumni Association and the Oklahoma State Medical Association to acquaint the public of the dire need of endowments and grants for which the Legislature would not be inclined to provide. Such contributions derived from endowments may be earmarked and used specifically for the purposes which the donor so desires.

Oklahoma is rich in resources and has many wealthy citizens; probably there are many other citizens of this state who, in view of the present tax situation, could afford to make benevolent contributions or endowments with but little financial sacrifice. We know that many of our citizens are philanthropically inclined and financially capable of doing something to increase the efficiency of the humanitarian work which the School of Medicine of the University of Oklahoma and the University and Crippled Children's Hospitals are doing. There are rare opportunities for these citizens to perform a real service for the fellow citizens of the State of Oklahoma. At the same time this situation offers a means of gratifying the generous impulses of anyone who may desire to leave his or her name as a benefactor of science, or to render a real service worth-while in memory of some loved ones.

Small contributions of equipment, such as; wheel chairs, beds, laboratory equipment and instruments, are needed and will be appreciated as well as large grants or endowments. Some of the needs of the University of Oklahoma Medical School suggested for donors to en-

dow are; Scholarships, Fellowships, Chairs, Research Institute, and Cancer Institute.

In February, 1945 the Endowment Committee of the School of Medicine, the Alumni President, the Dean of the School, and Mr. Fesler invited Mr. Lundy of Lundy and Company, a nationally known Fund Raising Organization, New York City to a dinner in the interest of endowment. Mr. Lundy pointed out that before large sums of money, three to five million, could be raised, it was necessary to finance a survey to see if it was possible to raise this amount. The survey would cost about \$2,500.00.

The Committee and the Alumni Executors have studied over the idea and all agreed that this must be done and that we would need a fund raising firm to aid us in this drive. The purpose of such assistance is to organize a definite campaign as to publicity and proper approach, but the members of the Alumni and State Medical Association must go to the donor to ask for the donations, not the fund raising firm.

The Alumni approved of this idea and \$1,900.00 has already been raised toward the \$2,500.00 through \$100.00 life memberships.

It was also explained that we have to date, without any drive or plan, \$37,000.00 which has been given in the last ten years.

To aid in this program, the ten Councilors appointed to represent different parts of the State of Oklahoma are: District 1, Dr. C. A. Traverse, Alva; District 2, Dr. J. E. Ensey, Altus; District 3, Dr. L. R. Willhite, Perkins; District 4, Dr. Onis G. Hazel, Oklahoma City; District 5, Dr. Roy Emanuel, Chickasha; District 6, Dr. Ralph McGill, Tulsa; District 7, Dr. John Carson, Shawnee; District 8, Dr. Matt Connell, Picher; District 9, Dr. E. H. Shuller, McAlester; District 10, Dr. P. H. Lawson, Marietta.

Mr. Dick Graham, Executive Secretary of the Oklahoma State Medical Association, 210 Plaza Court, Oklahoma City, offered his assistance in helping to carry out the endowment program and full use will be made of his office.

The Sooner Magazine, published by the University of Oklahoma Alumni Association will carry the news of the Medical School Alumni Association.

A motion was made and carried that the dues for the Alumni Association of the School of Medicine of the University of Oklahoma be \$13.00 per year (including \$3.00 for the Sooner Magazine), for regular members and \$8.00 per year (including \$3.00 for the Sooner Magazine) for associate members who are graduates of other Medical Schools; also, that the dues for life membership in the Medical School Alumni Association be \$100.00 and that the dues for life membership in both the Medical Alumni and the University of Oklahoma Alumni be \$760.00.

Lee K. Eganiser, M.D., 1014 Medical Arts Bldg., Oklahoma City, was elected President of the Alumni Association of the School of Medicine of the University of Oklahoma and John H. Lamb, M.D., 705 Medical Arts Bldg., Oklahoma City was re-elected Secretary-Treasurer. A rising vote of thanks was given by the Medical Alumni Association to Dr. William J. Finch, for his efficient and tireless work as President during the last three years.

It is not unpatriotic for a citizen to use part of his income for a philanthropy like the University of Oklahoma Foundation, designated for the Medical School to improve the health and morale of all classes of citizens in Oklahoma, and to aid in research to progress the science of medicine.

For deductions for income tax purposes, gifts to a philanthropy must be made by December 31 of the taxation year.



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The use of the index will be greatly facilitated by remembering that articles are often listed under more than one head. Scientific articles may be found under both the name of the author and the various phases of the subject discussed. Editorials, Book Reviews and Obituaries are listed under the special headings as well as alphabetically.

KEY TO ABBREVIATIONS

(S)—Scientific articles
(A)—Association Activities
(E)—Editorials
(SP)—Special Article
(pic)—Picture

(br)—Book Reviews
(abs)—Abstract
(o)—Obituary

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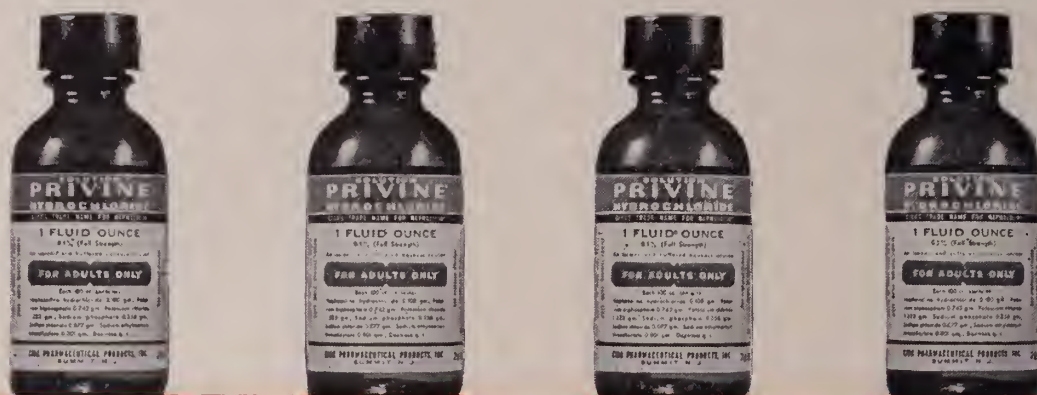
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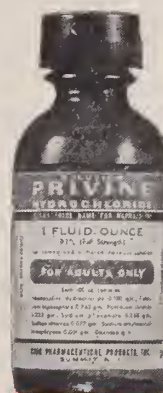
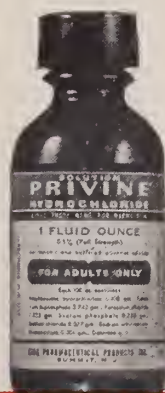
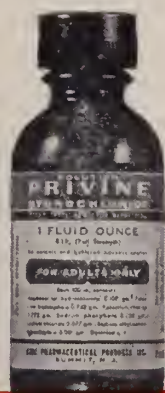
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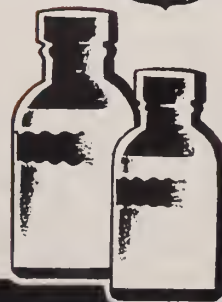
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*McCune, W. S., and Evans, J. M.: Intraventricular Penicillin in the Treatment of Staphylococcic Meningitis, J. A. M. A. 125:705 (July 8) 1944.

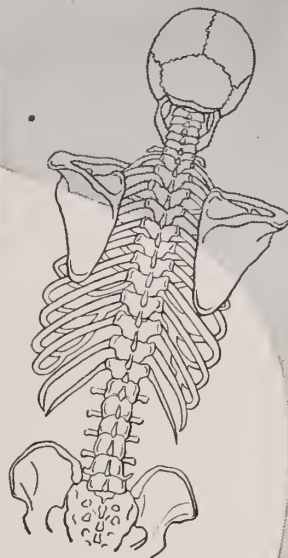
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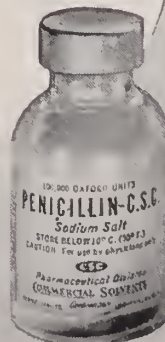
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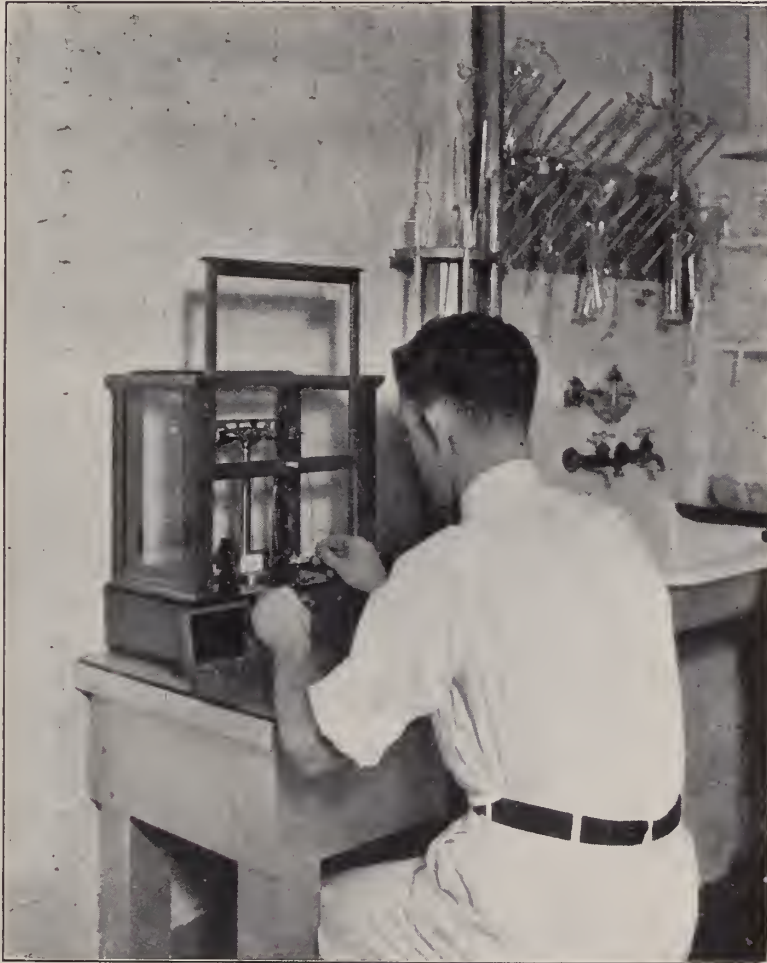
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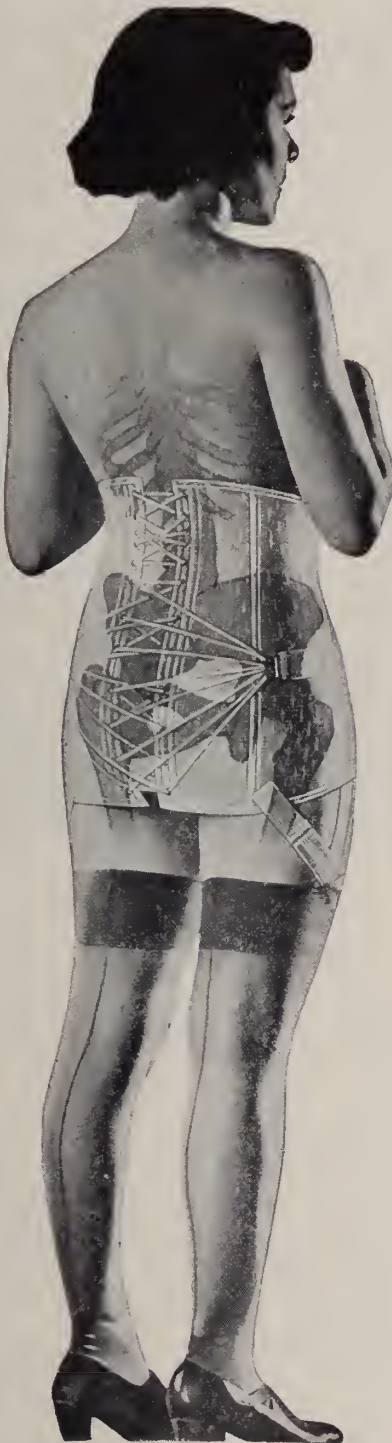
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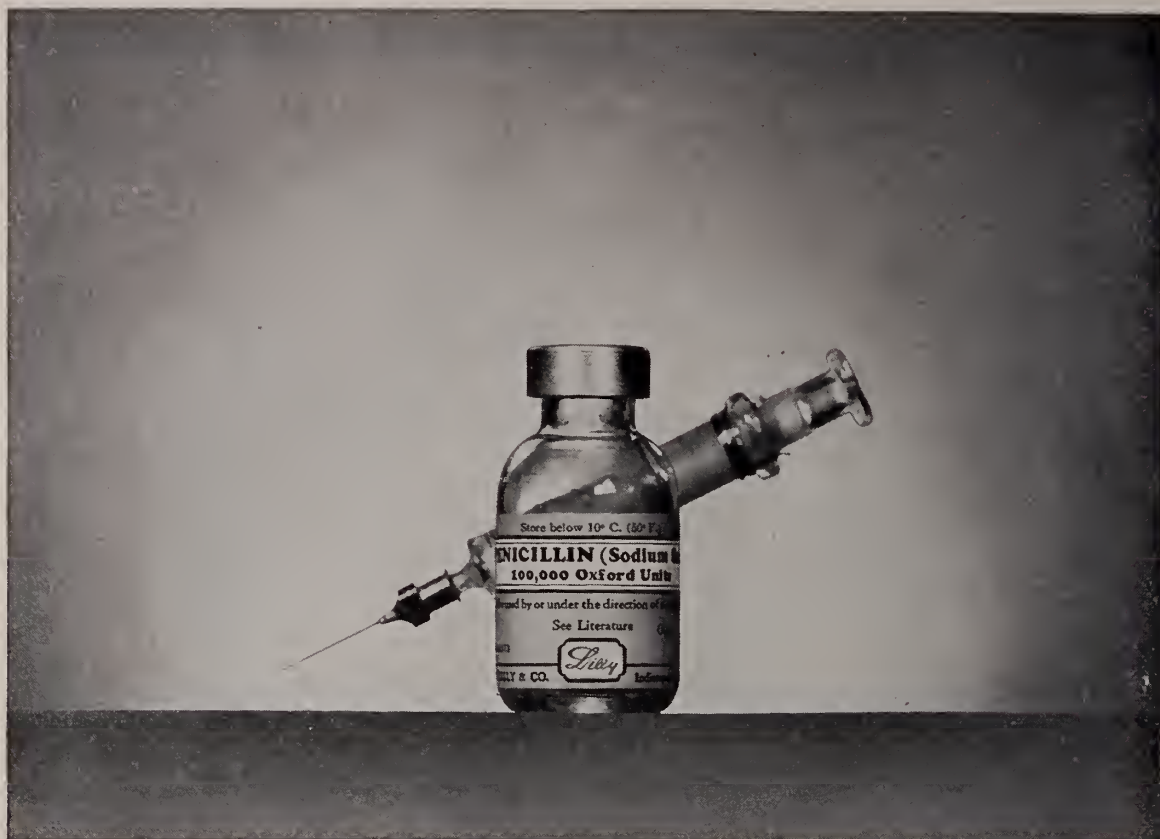
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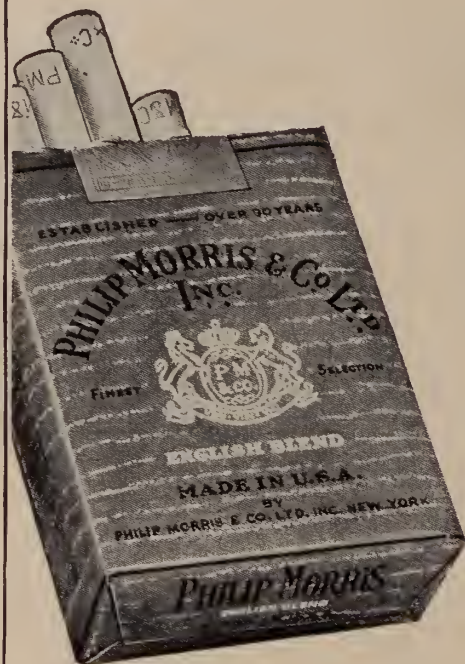
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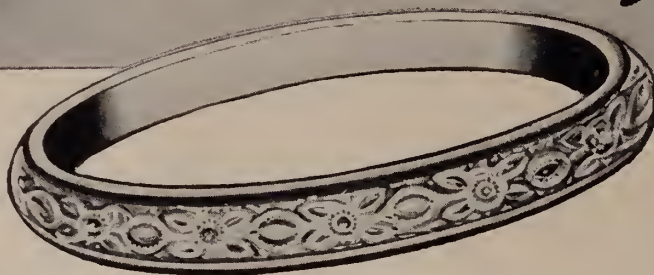
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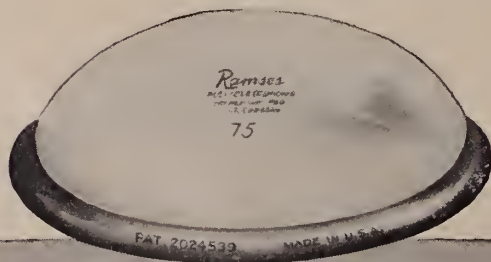
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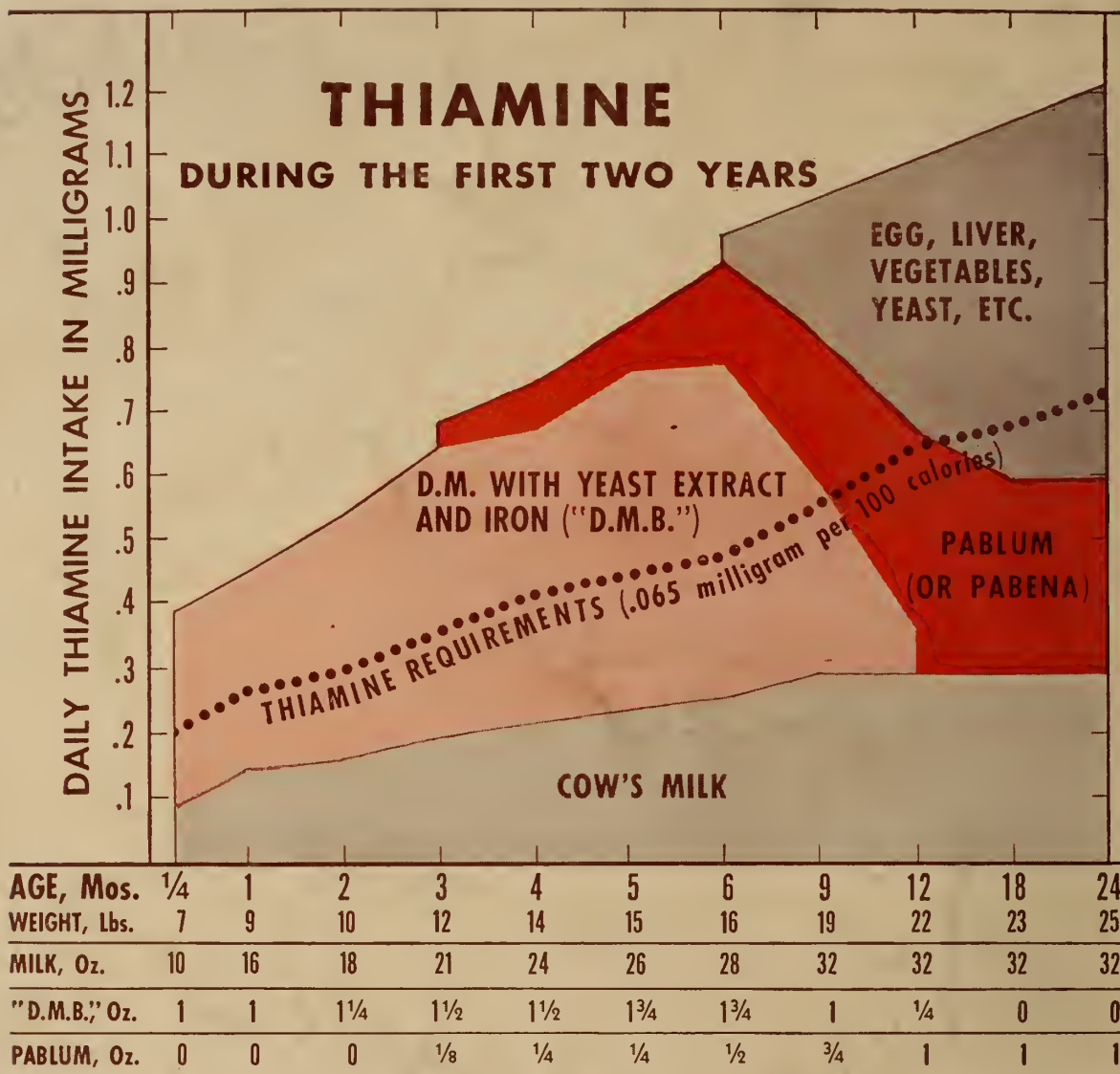
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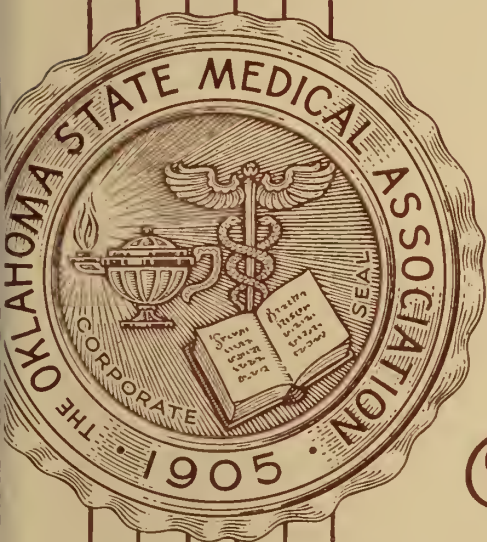
In clinical practice, it is desirable to allow a liberal margin of safety over calculated requirements. The chart shows that this safety factor may be assured when the carbohydrate is "D.M.B." and the cereal is either Pablum or Pabena.

VOL. XXXVIII

NUMBER 12

December, 1945

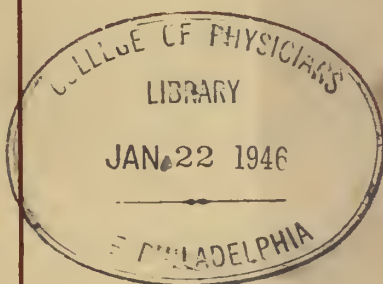
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Why do Tom, Dick and Harry need Vitamin D?



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IT DOES HAPPEN HERE

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Oleum Pereomorphum 50% is now known as Oleum Pereomorphum With Other Fish Liver Oils And Viosterol. A source of vitamins A and D in which not more than 50% of the vitamin D is derived from viosterol. The potency remains the same; namely, 60,000 vitamin A units and 8,500 vitamin D units per gram.

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